South Carolina General Assembly

Legislative Audit Council

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THE STATE OF SOUTH CAROLINA

GENERAL ASSEMBLY

LEGISLATIVE AUDIT COUNCIL

MANAGEMENT AUDIT

OF THE

MEDICAID PROGRAM IN

SOUTH CAROLINA

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ABBREVIATIONS

DSS	Department of Social Services
DHEC	Department of Health and Environmental Control
MMIS	Medicaid Management Information System
SNF	Skilled Nursing Facility
ICF	Intermediate Care Facility

PREFACE

A fundamental tenet of a democratic society holds that government agencies entrusted with public resources and the authority for applying them have a responsibility to render a full accounting of their activities. No governmental entity should ever be allowed to function beyond the reach of the people or their elected representatives. Total and unconditional disclosure, which is what accountability is all about, must be achieved if decisions are to be made on a basis of honesty, fairness, and objectivity. Accountability should be inherent to the governmental process. It is to this end that this report and all other work performed by the Legislative Audit Council is dedicated.

INTRODUCTION - SCOPE AND PURPOSE

The Legislative Audit Council was created under Act 1136 of 1974, as amended by Act 157 of 1975. The Council consists of three public members, elected by the General Assembly to non-concurrent six-year terms, and six ex officio members: The President of the Senate, the Speaker of the House of Representatives, Chairman of the Senate Finance Committee, Chairman of the House Ways and Means Committee, and Chairman of the Senate and House Judiciary Committees. The Council employs professional and clerical staff personnel who conduct audits under the supervision of the Council members.

The Legislative Audit Council provides a number of services to the General Assembly of South Carolina. It conducts audits and investigations of state or state related agencies and programs as referred to it by the General Assembly, Legislative Committees or Assembly members, and generates a schedule of audits of the operations of state agencies and departments to be performed periodically.

In this review, the Council examined the Department of Social Services' (DSS) management systems, policies, procedures, files, and records which affect the delivery of services provided by Medicaid. This included examining the system of processing and paying claims, monitoring and fraud investigation, utilization review of the quality and quantity of services, the accounting and budgeting of Medicaid funds, and the role of DSS's fiscal agency Blue Cross/Blue Shield.

Officials were interviewed from DSS, the Department of Health and Environmental Control (DHEC), the South Carolina Commission on Aging, and Blue Cross/Blue Shield. Also, discussions were held with HEW regional officials, DSS county administrators, nursing home administrators and nursing home patients.

BACKGROUND OF MEDICAID IN SOUTH CAROLINA

Medicaid is a program designed to provide medical services for persons who are unable to pay for such care. Authorized by Title XIX of the Social Security Act, as amended 42 U.S.C. 1396, Medicaid is a grant-in-aid program under which the federal government pays a portion of the costs incurred by states. The federal share of South Carolina's Medicaid costs in FY 76 was 73.58 percent.

The objective of Medicaid as stated in Section 1901 of the Act is: "to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the cost of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."

Medicaid is a federal-state program operated by the states within federal guidelines. Under such guidelines each state sets the eligibility factors governing who will be included in the program and what services they will be entitled to receive.

The program authorizes health care coverage for persons entitled to Public Assistance under the Social Security Act. These people, called categorically needy, include all persons eligible under the programs Aid to Families with Dependent children, AFDC, and Supplemental Security Income, SSI, (aged, blind, and disabled). Services provided to South Carolina's Medicaid recipients include:

(1) Physician Services

(2) Inpatient Hospital Services

(3) Outpatient Hospital Services

(4) Prescribed Drugs

(5) State Institutions

(6) Skilled Nursing Facilities

(7) Intermediate Care Facilities

(8) Dental Program

(9) Early Periodic, Screening, Diagnosis, and Treatment (EPSDT)

(10) Home Health Care Services

(11) Opthamologist

(12) Optometrist, Podiatrist, and Chiropractor Services

(13) Transportation

(14) Family Planning

(15) Co-Insurance and Deductibles

(16) Laboratory, X-ray, and Other Medical Services

(17) Supplemental Medical Income (SMI) Premiums (Part B of Medicare)

In FY 71, $34,533,780 was spent on Medicaid in South Carolina. By 1976 that figure rose to $109,945,263; up 218% from 1971. Of the funds expended in 1976, 78.8% went to pay for hospitals, nursing homes, physician services, and drugs. The following table illustrates the growth Medicaid has experienced.

MEDICAID GROWTH IN SOUTH CAROLINA

Fiscal Year	Total Medicaid Expenditures	% Increase from Prev. Year (expend.)	Number of Recip.	% Increase from Prev. Year (recip.)
1971	$ 34,553,780	-	83,641	-
1972	$ 39,077,313	13.0%	109,168	30.5%
1973	$ 46,473,586	18.9%	164,530	50.7%
1974	$ 57,307,076	23.3%	183,217	11.3%
1975	$ 84,732,117	47.8%	266,053	45.2%
1976	$109,945,263	29.7%	293,903	10.4%

The Department of Social Services is responsible for administering Medicaid in South Carolina. Within DSS, the Medical Assistance Division is responsible for managing the Medicaid Program in accordance with the state plan.

DSS has contracted with Blue Cross/Blue Shield of South Carolina to act as the fiscal intermediary in some programs. Blue Cross/Blue Shield processes reimbursements for services which make up 19% of the total Medicaid dollars. DSS processes the reimbursements for the remainder of the services.

OVERVIEW

The Legislative Audit Council's review of Medicaid in South Carolina found that the program is mismanaged and in many cases out of control. The Council found many instances where DSS management either failed to take any action at all on major problems or when action was taken it was late and inadequate. Further, the Council found considerable evidence of needless duplication, waste, mismanagement, lack of coordination, inadequate planning, and general lack of managerial imagination and initiative in the administration of the Medicaid Program. The result has been that millions of dollars have been misspent, wasted, and possibly stolen through provider or recipient fraud. In addition, DSS has obtained millions of dollars without providing justification to the Budget and Control Board and the Legislature. This has allowed management to function without any fiscal responsibility. It was also found that the Department of Health and Environmental Control has neglected its responsibility in administering some areas of the program.

Before detailing the Audit Council's findings and recommendations regarding the operation of Medicaid, it is helpful to review certain facts determined by the Audit Council during its ten month review of the program.

MEDICAID

- HAS GROWN 218% SINCE 1971.
- WAS A $109 MILLION PROGRAM IN FY 76 AND IS ESTIMATED TO BE $130 MILLION IN FY 77 and $160 MILLION BY FY 78.
- SERVED OVER 290,000 SOUTH CAROLINIANS IN FY 76.

- HAS OVER 5,000 PARTICIPATING PROVIDERS AND VENDORS OF SERVICES.
- IS AN EXTREMELY COMPLEX PROGRAM WITH NUMEROUS FEDERAL RULES AND REGULATIONS.

MISAPPLIED, MISMANAGED, AND WASTED STATE APPROPRIATIONS

- DSS HAS OBTAINED $40,986,513 ($17,370,672 APPROPRIATED TO MEDICAID) OVER THE LAST SIX YEARS WITHOUT PROVIDING WRITTEN JUSTIFICATION TO THE BUDGET AND CONTROL BOARD AND THE LEGISLATURE.
- $19,342,268 OF DSS'S FY 77 APPROPRIATION HAS NEVER BEEN JUSTIFIED.
- THE AGENCY HAS BECOME UNACCOUNTABLE TO ANYONE FOR A LARGE MAJORITY OF ITS SPENDING.
- NURSING HOME PATIENTS ARE GIVEN MORE EXPENSIVE CARE THAN IS NEEDED COSTING THE STATE AT LEAST $3.4 MILLION DURING THE LAST THREE YEARS.
- SOUTH CAROLINA MAY BE LIABLE TO THE FEDERAL GOVERNMENT FOR APPROXIMATELY 75%, $2.5 MILLION, OF THIS MONEY.
- DSS HAS NEGLECTED TO DEVELOP ALTERNATIVES TO INSTITUTIONALIZATION WHICH COULD SAVE AS MUCH AS $8 MILLION ANNUALLY WHILE BETTER MEETING THE NEEDS OF THE ELDERLY.
- DSS'S INVESTIGATION OF PROVIDER FRAUD HAS BEEN TOTALLY INADEQUATE FOR A PROGRAM THE SIZE OF MEDICAID. IT IS ESTIMATED BY HEW THAT THIS MAY BE COSTING THE STATE AS MUCH AS $5 MILLION ANNUALLY.

- NO PROVIDERS IN SOUTH CAROLINA HAVE EVER BEEN CONVICTED OF PROVIDER FRAUD.
- EVEN WHEN DSS HAS BEEN MADE AWARE OF OVERPAYMENTS TO PROVIDERS IT HAS FAILED TO TAKE THE NECESSARY STEPS TO DETERMINE IF FRAUD EXISTS IN SUCH CASES NOR HAS IT RECOVERED THE MONEY THROUGH ADMINISTRATIVE SANCTIONS OR LEGAL ACTION.
- THE EFFECT OF NONCOLLECTION OF OVERPAYMENTS IS TO ALLOW ABUSE AND POSSIBLY FRAUD OF THE MEDICAID PROGRAM.
- HEW ESTIMATES THAT A MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) COULD SAVE AS MUCH AS 4% IN PROGRAM EXPENDITURES ANNUALLY. THIS COULD HAVE REDUCED THE COST OF THE PROGRAM BY $4 MILLION IN FY 76.
- DSS'S PROCESSING OF DRUG CLAIMS IS INEFFICIENT AND IS WITHOUT PROPER CONTROLS TO ENSURE THAT ALL CLAIMS ARE VALID. THE CURRENT SYSTEM ALLOWS FRAUDULENT AND ACCIDENTAL DUPLICATE CLAIMS TO BE PROCESSED AND PAID WITHOUT DETECTION.

MANAGEMENT DEFICIENCIES

- EXCESSIVE FINANCIAL FLEXIBILITY HAS ALLOWED DSS NEITHER TO PLAN NOR SEEK SOLUTIONS FOR CONTROLLING PROGRAM COSTS.
- NO ONE PERSON WITHIN DSS HAS BEEN GIVEN THE RESPONSIBILITY TO MANAGE THE MEDICAID PROGRAM.
- DSS HAS FAILED TO HIRE A CHIEF (DIRECTOR) OF THE MEDICAL ASSISTANCE DIVISION, RESPONSIBLE FOR ADMINISTRATION OF MEDICAID, FOR TEN MONTHS.

- THE QUALIFICATIONS FOR THIS POSITION HAVE BEEN LOWERED AND ARE LESS STRINGENT THAN PERSONNEL WORKING UNDER THE CHIEF.
- THE HEADS OF EACH OF THE THREE BRANCHES WITHIN THE MEDICAL ASSISTANCE DIVISION HAVE ROTATED WEEKLY AS ACTING DIVISION CHIEF. THIS HAS RESULTED IN A LACK OF CONTINUITY OF MANAGEMENT SINCE NO ONE PERSON HAS THE AUTHORITY OR RESPONSIBILITY FOR MAKING THE EXTREMELY COMPLEX DAY-TO-DAY DECISIONS WHICH MUST BE MADE IN THIS PROGRAM.
- THE EXECUTIVE MANAGER RESPONSIBLE FOR MEDICAID IS ALSO RESPONSIBLE FOR OTHER MAJOR PROGRAMS, FOOD STAMPS ($173 MILLION), PUBLIC ASSISTANCE ($49 MILLION), AND CHILD SUPPORT ($680,000).
- THERE IS A LACK OF PLANNING AND COORDINATION AMONG THE VARIOUS PROGRAMS WITHIN MEDICAID, OTHER PROGRAMS ADMINISTERED BY DSS, AND OTHER STATE AGENCIES.
- DSS MANAGEMENT IS AWARE OF WASTEFUL UNNECESSARY SPENDING BUT HAS TAKEN NO ACTION TO CORRECT THESE CONDITIONS.
- ACTION BY DSS MANAGEMENT IN MANY CASES IS SLOW AND WHEN A DECISION IS MADE IT IS TOO LATE AND INADEQUATE TO REMEDY THE PROBLEM.
- THE DECISION-MAKING PROCESS IS CUMBERSOME, UNWIELDY AND SLOW EVEN FOR ROUTINE DECISIONS.
- MANAGEMENT'S EFFORTS ARE FOCUSED ON RESPONDING TO CRISIS SITUATIONS RATHER THAN ON OVERALL CONTROL.
- DSS MANAGEMENT HAS BEEN SURROUNDED IN CONSTANT CONTROVERSY AND SUSPICION FOR OVER 1½ YEARS WHICH HAS SERIOUSLY HINDERED MANAGEMENT OF ITS PROGRAMS.

- EMPLOYEE MORALE IS LOW WITH FRUSTRATIONS OFTEN BEING EXPRESSED CONCERNING THE LACK OF LEADERSHIP AND ABSENCE OF DECISION-MAKING.

NURSING HOMES

- 65-75% OF ALL PERSONS IN SOUTH CAROLINA NURSING HOMES ARE ON MEDICAID.
- MEDICAID NURSING HOME EXPENDITURES HAVE RISEN 200% IN THE LAST FIVE YEARS.
- REIMBURSEMENT RATES FOR INTERMEDIATE CARE FACILITIES (ICFs) AND SKILLED NURSING FACILITIES (SNFs) HAVE RISEN 212% AND 93% RESPECTIVELY OVER THE LAST FIVE YEARS WHILE THE CONSUMER PRICE INDEX FOR MEDICAL CARE HAS RISEN 31.3%.
- SOUTH CAROLINA'S MEDICAID PROGRAM RANKS 15TH IN THE NATION IN THE AVERAGE PAYMENT PER DAY FOR SNF CARE. THIS IS HIGHER THAN OTHER SOUTHEASTERN STATES.
- THE PER PATIENT DAILY PAYMENT CEILINGS ESTABLISHED BY DSS TEND TO BE MUCH HIGHER THAN THOSE ESTABLISHED IN OTHER STATES.
- SOUTH CAROLINA RANKS 49TH IN THE NATION IN PER CAPITA INCOME.
- THE RESPONSIBILITIES FOR ADMINISTERING THE NURSING HOME PROGRAM ARE FRAGMENTED BETWEEN DSS AND DHEC.
- THE LACK OF EFFECTIVE COORDINATION BETWEEN DSS AND DHEC PLACES THE NURSING HOME INDUSTRY IN AN EXTREMELY ADVANTAGEOUS POSITION IN THE NEGOTIATION OF PER PATIENT DAY PAYMENT CEILINGS.
- DSS IS RESPONSIBLE FOR SETTING REIMBURSEMENT RATES, PROPER CLASSIFICATION AND PLACEMENT OF PATIENTS, AND REVIEW OF EACH PATIENT FOR APPROPRIATE PLACEMENT.

- INAPPROPRIATELY PLACED NURSING HOME PATIENTS HAVE COST THE STATE $3.4 MILLION IN UNNECESSARY PAYMENTS OVER THE LAST THREE YEARS.
- DHEC APPROVES APPLICATIONS FOR NURSING HOME CONSTRUCTION, INSPECTS AND LICENSES NURSING HOMES AND CERTIFIES HOMES FOR PARTICIPATION IN MEDICAID.
- DHEC MAINTAINS SEPARATE DIVISIONS FOR STATE LICENSURE AND MEDICAID CERTIFICATION OF NURSING HOMES. THE DIVISIONS DUPLICATE EACH OTHER'S WORK COSTING THOUSANDS OF DOLLARS A YEAR.

ALTERNATIVES TO INSTITUTIONALIZATION

- DELAYING INSTITUTIONALIZATION OF ELDERLY PERSONS AS LONG AS POSSIBLE WILL KEEP THEM FROM BECOMING ISOLATED, UNINVOLVED, AND NO LONGER AN INTEGRAL PART OF THE COMMUNITY.
- 30% OF THE PATIENTS IN NURSING HOMES COULD BE RELEASED IF ALTERNATIVE SERVICES WERE AVAILABLE.
- DSS HAS NOT DEVELOPED A POLICY OR COORDINATED PROGRAM FOR USING THE RESOURCES WHICH ARE AVAILABLE IN THE STATE.
- ALTERNATIVES TO NURSING HOMES IF DEVELOPED COULD SAVE AS MUCH AS $8 MILLION ANNUALLY WHILE BETTER MEETING THE NEEDS OF THE ELDERLY.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

- DSS DOES NOT HAVE AN ADEQUATE MMIS TO EFFICIENTLY AND EFFECTIVELY ADMINISTER THE PROGRAM.

- THE NEED FOR AN EFFECTIVE MMIS IN SOUTH CAROLINA HAS BEEN KNOWN SINCE 1971.
- THE FEDERAL GOVERNMENT WILL PAY 90% FOR THE DEVELOPMENT AND IMPLEMENTATION OF A MMIS AND 75% OF ITS OPERATING COSTS.
- DSS'S UTILIZATION REVIEW AND CONTROL SYSTEM TO DETERMINE THE APPROPRIATENESS OF MEDICAL CARE PROVIDED AND TO PREVENT OVERUTILIZATION OF SERVICES IS INADEQUATE.
- DSS HAS NOT COMPLIED WITH HEW AUDIT RECOMMENDATIONS OF 1972 AND FEDERAL REGULATIONS WHICH REQUIRE RECIPIENT AND PROVIDER PROFILES TO BE DEVELOPED.
- DSS RESPONDED TO HEW AUDIT RECOMMENDATIONS IN 1973 BY SAYING THE RECOMMENDATIONS WOULD BE IMPLEMENTED WHEN A MMIS WAS OPERATIONAL. A MMIS IS NON-EXISTENT 3½ YEARS LATER.
- DSS HAS NOT BEEN ABLE TO MAKE WISE AND TIMELY PROGRAM AND POLICY DECISIONS BECAUSE OF THE LACK OF MANAGEMENT INFORMATION.
- HEW ESTIMATES THAT A MMIS COULD SAVE AS MUCH AS 4% IN PROGRAM EXPENDITURES ANNUALLY. THIS COULD HAVE REDUCED THE COST OF THE PROGRAM BY $4 MILLION IN FY 76.

CONCLUSION

It must be concluded from the problems and findings of this review that there is a lack of leadership, management direction, and policy making within DSS. Consequently, administration of the Medicaid Program is ineffective and inefficient. There are no easy

solutions to the Medicaid Program. However, the recommendations which follow when taken together should aid the Legislature in gaining control over the program if strong and prompt action is taken. The magnitude of Medicaid and its far reaching effects on the people demand that competent qualified individuals with the appropriate authority take control over the program.

INADEQUATE AND INEFFECTIVE MANAGEMENT OF MEDICAID

The Legislative Audit Council's review found the management of Medicaid to be inadequate and ineffective. Medicaid's management problems result from the lack of overall executive leadership and management within the Department of Social Services. The Medicaid Program suffers from an unwieldy and cumbersome method of making decisions and establishing management policies. The Council found no single person within DSS with the responsibility and authority to resolve the problems of Medicaid nor can any one manager be held responsible for the program. To get attention, problems must rise through the agency's bureaucracy to a top management committee of four Deputy Commissioners. Problems are not diagnosed until they have become crises. Action by DSS management is slow and when a decision is made it typically is inadequate to remedy the problem.

No one person within DSS has been given the responsibility to manage the Medicaid Program. The Medical Assistance Division, responsible for administration of Medicaid, has been without a Chief (director) since February, 1976 when the previous director died. Since then the heads of each of the three branches within the division have rotated weekly as Acting Division Chief. This has resulted in a lack of continuity of management, and in turn prevents anyone from having the necessary decision-making authority to run the program effectively. Three persons rotating weekly as division head cannot properly manage the program, since no one individual has the authority or responsibility for making the extremely complex day-to-day decisions which must be made in this

program. The Council could find no reason for the long delay in filling this important position. It cannot be emphasized strongly enough that a program with the complexity and magnitude of Medicaid ($130 million in FY 77) must have a full time qualified director with the authority to administer it.

Additionally, the qualifications and requirements for the Chief's position have been lowered and are now less stringent than the subordinate branch heads. This means that the Medical Assistance Division Chief's qualifications can be lower than those of the personnel working under him. Again the Council found practices which defy generally accepted management standards. Proper personnel management would require that the Medical Assistance Division Chief have more training and experience than people working under him. This management structure is inadequate and will inevitably continue to cause serious management problems.

Management problems are further compounded because the executive manager is responsible for other major programs besides Medicaid. The Deputy Commissioner over the Medical Assistance Division is not only responsible for the $130 million Medicaid Program but is also in charge of Public Assistance ($49 million), Food Stamps ($173 million), Child Support ($680,000), and the Indo-China Refugee Program ($250,000). Also, this Deputy Commissioner has taken on the duties of the vacant Chief Deputy Commissioner's position. With all of these responsibilities the Deputy Commissioner cannot give the necessary leadership and attention which is required to solve the Medicaid Program's problems.

The decision-making process is set up so that decisions are only made after approval is obtained from all of the other Deputy

Commissioners and the Commissioner. Thus, a void exists within the program's management. It creates a system wherein no one has the responsibility combined with the authority and information necessary to control the program. Management's efforts are actually focused more on crisis situations than on overall control. Also, this management by "committee" means that no single manager may be held accountable for decisions that are made.

There are other major weaknesses in the process for decision-making in the agency. One problem is the unfilled director's position. Another problem, as revealed through discussions with employees, is the slowness and the complexity of the procedures for making routine decisions. For example, within the Medical Assistance Division, minor decisions had to go from the division's branch head to the branch head acting as Division Chief for approval. From there the request would go to the Deputy Commissioner who, if in agreement with the request, will bring it before the remaining Deputy Commissioners. If they approve the matter, the decision would then go to the Commissioner for his approval or disapproval. As long as the decision-making process remains so cumbersome and unwieldy, a problem will not likely be given attention until it becomes a crisis, the response from management will be slow, and when a decision is made it will be late and inadequate.

The Legislative Audit Council believes that all of the problems and findings which follow in this report are the result of poor management and indecisive leadership. DSS has allowed another crisis situation to occur as Medicaid funds for FY 78 are projected

to be far short of what will be needed. There is a lack of planning for Medicaid and a shortage of information to facilitate such planning. Financial flexibility as provided by the carryforward funds has allowed management to forego the major managerial task of insightful planning for the future. The agency has failed to face, resolve, or even seek solutions to its problems and instead of disappearing, they continue to grow. The program is out of control and it is the taxpayer who must bear the cost of this mismanagement.

The size of the Medicaid Program and its effect on South Carolinians make these conditions a serious matter. The Medicaid Program cost $109 million in FY 76. It served over 290,000 people through more than 5,000 providers. It may cost as much as $130 million in FY 77 and $160 million in FY 78. There is at this time a great need for competent administrators and information to control the program's expansion. Adequate information can be provided by a properly implemented information system. But this information must be put in the hands of skilled managers who recognize the problems, are willing and authorized to act, and who are held accountable for their actions. So far as the Council's audit was able to determine, such managers are not presently in charge of the Medicaid Program.

RECOMMENDATIONS

- DSS SHOULD ESTABLISH SPECIFIC LINES OF RESPONSIBILITY AND AUTHORITY FOR THE MANAGEMENT OF THE MEDICAID PROGRAM SO THAT THE OFFICIALS RESPONSIBLE FOR MEDICAID WILL ALSO BE ACCOUNTABLE.

- DSS SHOULD FILL THE POSITION OF MEDICAL ASSISTANCE DIVISION CHIEF AS SOON AS POSSIBLE WITH AN INDIVIDUAL POSSESSING APPROPRIATE SKILLS AND MANAGERIAL EXPERIENCE.
- DSS SHOULD ESTABLISH A MANAGEMENT SYSTEM FOR LONG-RANGE PLANNING AND COORDINATED POLICY FORMATION AMONG THE VARIOUS PROGRAMS IT ADMINISTERS. THIS SHOULD INCLUDE PROCEDURES FOR BETTER MONITORING AND CONTROLLING PROGRAMS AND DECISIONS REGARDING THOSE PROGRAMS.
- BETTER COORDINATION SHOULD BE ESTABLISHED WITH DHEC, THE COMMISSION ON AGING AND OTHER STATE AGENCIES SO THAT THE SERVICES NEEDED BY SOUTH CAROLINIANS CAN BE MORE EFFECTIVELY PROVIDED.
- THE GENERAL ASSEMBLY AND THE STATE REORGANIZATION COMMISSION SHOULD EXAMINE THE FEASIBILITY OF PLACING THE ADMINISTRATIVE RESPONSIBILITY FOR ALL SOCIAL-HEALTH PROGRAMS IN THE STATE UNDER A SINGLE AGENCY. THERE ARE SEVERAL REASONS FOR THIS APPROACH:
  - THE COUNCIL'S EXAMINATION OF THE MEDICAID PROGRAM FOUND THAT DSS DOES NOT POSSESS THE MANAGEMENT CAPABILITIES NECESSARY TO PROPERLY ADMINISTER THE PROGRAM AND THAT DHEC HAS ADMINISTRATIVE PROBLEMS ALSO;
  - DSS IS A WELFARE AGENCY, BUT IT IS RESPONSIBLE FOR ADMINISTERING THE MEDICAID PROGRAM WHICH COMBINES WELFARE AND HEALTH AND MEDICAL CARE SERVICES. THE STATE HEALTH AGENCY (DHEC)

DOES NOT ADMINISTER THE MEDICAID PROGRAM, DESPITE THE FACT THAT THE PROGRAM IS BASICALLY A HEALTH CARE PROGRAM;

- THE FEDERAL GOVERNMENT HAS USED, AND WILL CONTINUE TO USE, A COMPREHENSIVE APPROACH IN ADDRESSING HEALTH AND WELFARE PROBLEMS (UNDER HEW) AND A SIMILAR APPROACH WOULD INCREASE EFFICIENCY AND EFFECTIVENESS IN THE ADMINISTRATION OF COMPREHENSIVE FEDERAL PROGRAMS AT THE STATE LEVEL;
- A NUMBER OF OTHER STATES HAVE SUCCESSFULLY INSTITUTED COMPREHENSIVE HEALTH AND WELFARE PROGRAMS UNDER DEPARTMENTS OF HUMAN RESOURCES OR LIKE AGENCIES; AND
- THIS APPROACH WOULD ELIMINATE THE LACK OF COORDINATION, FRAGMENTATION OF RESPONSIBILITIES AND OTHER PROBLEMS RELATED TO THE RELATIONSHIP BETWEEN DSS AND DHEC AND THE ADMINISTRATION OF MEDICAID AS WELL AS OTHER SOCIAL-HEALTH PROGRAMS.

THE COUNCIL'S EXAMINATION AND ANALYSIS OF THIS AREA PROVIDES STRONG EVIDENCE THAT A COMBINED, COMPREHENSIVE HEALTH AND WELFARE AGENCY WOULD BE BETTER EQUIPPED TO SUCCESSFULLY MANAGE THESE PROGRAMS AND MEET THE NEEDS OF THE CITIZENS OF SOUTH CAROLINA.

NURSING HOMES

Rising costs in the nursing home program have been one of the major causes of the increasing cost in the state's Medicaid Program. The nursing home program consists of skilled care nursing facilities (SNFs) and intermediate care facilities (ICFs). The program currently accounts for 35 percent of the total Medicaid budget while serving 3.8 percent of the Medicaid population. The number of persons served has increased from 5,380 in FY 71 to 11,399 in FY 76. At present there are 8,861 licensed nursing home beds in the state: 5,562 SNFs and 3,299 ICFs. Seventy-five percent (75%) of these beds are occupied by persons on Medicaid.

With this growth in the Medicaid nursing home program services, expenditures have increased 200% from $13.8 million in FY 71 to $38.8 million in FY 76. Using merely the current growth rate in expenditures, in five years South Carolina can anticipate spending more than $100 million annually, just in the nursing home program portion of Medicaid!

The rising cost of the nursing home program is a serious and complex problem involving numerous politically sensitive and emotion-laden issues, and is reflective of a national trend. In spite of these factors, the Audit Council has found areas where substantial savings can be gained and the delivery of services can be improved by making relatively minor changes in the program's current administrative procedures and ensuring that competent managers are employed who are properly equipped to make hard decisions.

These findings reflect the considerable evidence of needless duplication, waste, mismanagement, lack of coordination, inadequate

planning, and general lack of managerial imagination and initiative found in the administration of the nursing home program.

The Audit Council found the following situation to exist. South Carolina's Medicaid Program ranks 15th in the nation in the average payment per day for SNF care. This becomes a significant factor considering that South Carolina ranks 49th nationally in per capita income and thus has rather limited resources to allocate to Medicaid. Further, South Carolina's average daily payment is higher than in other southeastern states, e.g., Florida, Georgia, North Carolina, Alabama, Texas and Virginia.

DSS, in negotiation with the nursing home industry, has established payment ceilings of $28 and $20.80 per patient day for SNFs and ICFs respectively. Since 1971, this is an increase of 93% for SNFs ($14.50 to $28 per patient day). It is an increase of 212% for ICFs ($6.67 to $20.80 per patient day). During this same period the consumer price index only rose 32.9% and the consumer price index for medical care rose only 31.3%.

Further, the per patient day payment ceilings which DSS has established are much higher than those established in other states, e.g., Alabama $21.50 SNF/$19.35 ICF; Georgia $18.08 SNF/$16.44 ICF; and California $20.73 SNF/$16.73 ICF.

Upon further analysis, the Audit Council found that the inappropriate placement of nursing home patients has resulted in overpayments of $3,436,475 in the last three fiscal years. DSS has stated that even under the most generous interpretation of level of care regulations, there are in excess of 500 persons who are classified

for intermediate care but occupy the more expensive skilled care beds because the less expensive intermediate care beds are not available. They state that the minimum estimate of 500 inappropriate placements has remained constant for the last three years. The following table illustrates the overpayment estimation procedure.

	Difference in Average Daily Rate (SNF-ICF)	Number of Patients in SNF Beds that only Need ICF Care	Number of Days in the Year	Estimation of Overpayment
FY 74	$6.10	500	365	$1,113,250.00
FY 75	6.48	500	365	1,182,600.00
FY 76	6.25	500	365	1,140,625.00
			TOTAL	$3,436,475.00

Because of these overpayments the State of South Carolina could be found liable to the federal government for 75% of the total amount, approximately $2.5 million.

There are four major reasons for the high number of inappropriate placements. Frequently, patients who require skilled care when first admitted to a nursing home will improve to an extent where they only require intermediate care. However, if there is a shortage of intermediate care beds, the patient will remain in a skilled care bed and DSS will continue to pay the higher rate.

A second reason is that DSS has not effectively implemented actions within its statutory authority to significantly alter the ratio of SNF beds to ICF beds. The current ratio is 62 SNF/37 ICF. DSS has admitted to the accuracy of several studies conducted elsewhere which conclude that there should be a much higher proportion of ICF beds.

A third reason is that DHEC has not been effective in its procedures for estimating the number of beds of each type which will be needed. For example, in contrast to the conclusions cited above, DHEC's method for projecting future needs consistently predicts a greater need for SNF beds than ICF beds. One cause of this discrepancy apparently is their heavy reliance on the usage rates for previous years. Inherent in their estimation method is the faulty assumption that usage rates accurately reflect needs. Further, their procedure does not permit adjustments for the impact of the many patients whose condition improves so that they progress from requiring skilled care to only requiring intermediate care.

The Audit Council has found the fourth reason clearly to be the most important factor. The responsibilities for administering the nursing home program are fragmented between DSS and DHEC. This has allowed both agencies, when questioned about the inadequacies and waste in the program, to point the finger of blame at each other. In general, the Audit Council has concluded that both agencies have failed in their managerial responsibilities to coordinate closely in a businesslike, professional manner in defining the problems and in developing efficient and effective solutions.

In spite of the fragmented responsibilities between DSS and DHEC in the nursing home program, both agencies have very powerful statutory authority to develop a coordinated approach to resolving the problems cited above.

In the nursing home program, DHEC has three basic functions. It approves applications for nursing home construction. Second,

it inspects and licenses nursing homes. Third, it certifies nursing homes for participation in Medicaid. Through the combination of these three statutory responsibilities, DHEC has considerable indirect influence on the number and type of nursing home beds available to Medicaid.

As self-designated "appropriate state medical agency," DSS has responsibility for Medicaid patient placement. DSS evaluates the needs of Medicaid clients and determines whether or not they need nursing home care. Further, the agency determines which level of care is appropriate for the client. In this area it is clear that DSS has failed to establish comprehensive, stringent, and uniform medical criteria for determining placement needs of the individual. Without such a framework and without keeping records of patient placement and progress within the framework, DSS has no effective means of estimating the future size nor the future needs of the Medicaid nursing home population.

In the absence of a comprehensive system of evaluating, recording, and following the characteristics of Medicaid nursing home patients, it is even more inexcusable that DSS has failed to establish effective coordination with DHEC in planning for the Medicaid nursing home program.

DHEC, on the other hand, in addition to using an inadequate method for projecting community needs for nursing home beds, has demonstrated poor managerial judgement in failing to aggressively pursue development of a coordinated nursing home planning program with DSS.

DSS, however, as the single agency in the state responsible for the administration of Medicaid, must bear the brunt of the

responsibility for the effects of the failures and inadequacies in the Medicaid Program. The extent of the effects on the state's Medicaid population will remain unknown. Some of the financial costs due to inefficiency have been cited above and elsewhere in this report. There is another effect which is not readily apparent.

The lack of effective coordination between DSS and DHEC places the nursing home industry in an extremely advantageous position in the negotiation of per patient day payment ceilings. The industry can virtually dictate to the state the rate of payment for a resource over which they exert a near monopolistic control in the absence of effective coordination in regulation and planning between DSS and DHEC.

A related effect is that in the absence of reasonable competition among South Carolina's nursing home businesses, it is difficult to evaluate whether or not the real nursing home needs of the state are being adequately met at the most reasonable cost.

The net effect of the current situation is that DSS has weakly attempted to control costs through limiting services. In fact, in every budget review session DSS has disguised inept management through diversionary and misleading tactics. They frequently claim that an interference with their current operational procedures and budgetary system will inevitably result in a reduction of services to the needy. This tactic has successfully appealed to emotionalism and has diverted attention from the managerial inadequacies in DSS.

It is neither viable nor humane to threaten to contain costs through the limitation of services. Costs must be contained

through the establishment of uniform criteria and the stringent monitoring and enforcement of those criteria for nursing home placement in a manner which is consistent with the state's resources. Otherwise, South Carolina faces the prospect of sharing the unfortunate and costly experience of its sister states in the accumulation of Medicaid deficits far in excess of the state's fiscal resources.

RECOMMENDATIONS

- IF NURSING HOME PROGRAM COSTS ARE TO BE EFFICIENTLY CONTROLLED, STATEWIDE UNIFORM MEDICAL CRITERIA FOR ADMISSION TO THE MEDICAID NURSING HOME PROGRAM MUST BE ESTABLISHED. REALIZING THAT THE STATE'S RESOURCES ARE FINITE, THE CRITERIA MUST BE FAIR AND EQUITABLE BUT THEY ALSO MUST BE STRINGENTLY ENFORCED WITHIN THE CONTEXT OF THE STATE'S RESOURCES.
- THE CURRENT METHOD EMPLOYED BY DHEC TO ESTIMATE THE NUMBER OF NURSING HOME BEDS NEEDED IN THE FUTURE SHOULD BE REVIEWED IMMEDIATELY AND STEPS TAKEN TO IMPROVE THE ACCURACY OF THE ESTIMATION PROCEDURE.
- A THOROUGH INVESTIGATION OF ALTERNATIVES TO NURSING HOME INSTITUTIONALIZATION SHOULD BE IMMEDIATELY INITIATED (SEE P. 31).
- A POLICY AND A SYSTEM SHOULD BE QUICKLY ESTABLISHED WHICH REIMBURSES NURSING HOMES FOR PATIENT CARE SOLELY ON THE BASIS OF THE LEVEL OF CARE APPROPRIATE TO THE PATIENT'S CONDITION. EVEN THOUGH A NURSING HOME MAY ONLY HAVE SKILLED CARE BEDS AVAILABLE, EXPERIENCE FROM

OTHER STATES HAS SHOWN THAT NURSING HOMES WILL OBTAIN RECERTIFICATION FOR INTERMEDIATE CARE BEDS. PAYMENT FOR A LEVEL OF CARE ABOVE THE LEVEL FOR WHICH A PATIENT IS CERTIFIED SHOULD BE PROHIBITED BY LAW.

- THE ABOVE RECOMMENDATION IS MADE MORE FEASIBLE IN LIGHT OF HEW'S RECENT RULING THAT STATES MAY REQUIRE ALL SKILLED CARE NURSING HOMES WHICH PARTICIPATE IN MEDICAID TO BE DUALLY CERTIFIED TO PROVIDE BOTH SKILLED AND INTERMEDIATE CARE. SUCH A PROCEDURE SHOULD BE LOOKED INTO AND POSSIBLY IMPLEMENTED IN SOUTH CAROLINA BY STATUTE.
- A UTILIZATION REVIEW SYSTEM FOR CONTINUOUS VERIFICATION OF APPROPRIATENESS OF NURSING HOME PATIENT PLACEMENT SHOULD BE ESTABLISHED. THE SYSTEM, IN CONJUNCTION WITH THE ESTABLISHMENT OF UNIFORM MEDICAL CRITERIA, SHOULD CENTER AROUND A MEDICALLY QUALIFIED REVIEW TEAM WHICH IS COMPLETELY INDEPENDENT OF THE NURSING HOME INDUSTRY. THIS COULD BE ACCOMPLISHED BY THE SOUTH CAROLINA MEDICAL CARE FOUNDATION WHICH IS THE STATE'S PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO) FOR MEDICAID AND MEDICARE. AN ADDITIONAL BENEFIT OF SUCH A SYSTEM WOULD BE THAT IT WILL AFFORD SOME PROTECTION FOR THE MEDICAL COMMUNITY AGAINST THE FREQUENTLY LEVELED ALLEGATIONS OF ABUSE OF THE MEDICAID PROGRAM.
- THE ADMINISTRATIVE RESPONSIBILITIES FOR THE NURSING HOME PROGRAM, WHICH CURRENTLY ARE FRAGMENTED BETWEEN TWO AGENCIES, SHOULD BE CONSOLIDATED UNDER ONE AGENCY (SEE P. 19).

DUPLICATION OF LICENSURE AND CERTIFICATION OF NURSING HOMES

DHEC conducts separate inspections of nursing homes for state licensure and for federal Medicaid certification which is an unnecessary duplication of functions. South Carolina is the only state in the southeast that has not combined these functions. DHEC's maintaining of separate Certification and Licensing Divisions for inspecting nursing homes wastes state resources. These divisions inspect nursing homes to ensure that they maintain state and federal standards. The licensing and certification teams make separate visits in conducting their respective inspections. The Medicaid certification inspection reviews the same areas as the licensing inspection but in more depth. Most nursing homes and hospitals in South Carolina besides meeting the standards for licensure are also certified for participation in Medicaid and/or Medicare. Thus, it would be expected that DHEC would combine these functions and visit each facility only once for both licensure and certification inspections.

HEW recommends that states combine the state licensure and federal certification functions. The HEW Atlanta Regional Office encouraged DHEC to do this in a review of the certification activities in August 1975. This report stated that, "for the record, the Regional Office supports <u>one</u> visit for both the licensure and certification processes and emphasizes that close coordination of licensure and certification is essential in fulfilling the intent of federal requirements." (Emphasis in original)

The Division of Certification has staff positions for 33 persons and is funded almost totally with federal funds. Its expenditures in FY 76 were $490,487. The Division of Licensing has a staff of 14 persons. It spent $178,781 in FY 76 and its funds came mainly from state appropriations. Combining these functions will not produce savings of all the state funds now spent in the Licensing Division because the state would have to pay for a portion of the combined licensing and certification visit. However, there should be substantial savings available in staff and travel. Another advantage of making one visit is that it would allow for more efficient and effective use of staff. Also, it does not provide as great a hardship on nursing home staff as do two separate inspections.

Inspection of nursing homes is very important to ensure that quality care is being provided. The Legislative Audit Council advocates DHEC visiting nursing homes more than once a year. The certification process requires follow-up visits to nursing homes to ensure that deficiencies are corrected. Also, a portion of the savings gained from combining the licensing and certification functions could be used for "surprise" visits to review homes.

RECOMMENDATION

- DHEC SHOULD COMBINE THE STATE LICENSURE AND FEDERAL CERTIFICATION FUNCTIONS FOR NURSING HOMES. ONE INSPECTION VISIT SHOULD BE MADE FOR THE LICENSURE AND CERTIFICATION PROCESSES.

ALTERNATIVES TO INSTITUTIONALIZATION NEEDED

Alternatives to nursing homes if properly developed could save the state as much as $8 million while better meeting the needs of the elderly. South Carolina at the present time has not made a commitment to or developed a program for providing less expensive alternatives to institutionalization. Within the Medicaid Program, DSS has placed little, if any, emphasis on providing alternatives to nursing homes. Also, there is a lack of coordination with the other programs administered by DSS and other agencies which could be used in providing alternatives for the elderly. There is not a policy or coordinated program for using the resources which are available in the state. Services which are available are not fully developed and utilized to prevent unnecessary nursing home care. One study estimates that 30% of the patients in nursing homes could be released if alternative services were available. In essence, this is one of those rare situations where better meeting the needs of the people can result in cost savings.

As stated earlier, in FY 71, $13.8 million was being spent by Medicaid on nursing homes. In FY 74, that figure rose to $20.1 million and in FY 76, $38.8 million went to pay for Medicaid patients who are in nursing homes. Because of recent court decisions which mandate the removal of older patients at Crafts-Farrow State Hospital, the amount of money South Carolina will need to support Medicaid patients in nursing homes will increase at an even greater rate.

In addition, projected figures show a sharp increase in future years with an anticipated elderly population in South Carolina of 239,700 by 1980 and 287,794 by the year 1990. The

problem becomes more complicated when one remembers that the average life span has increased from 47 years in 1900 to 71 in 1970 and at the same time, this culture is experiencing a decline in the extended family. For example, in 1973, 46,000 or 23% of the 200,000 elderly in South Carolina, lived alone. These are the people who must have alternatives made available to them if they are to avoid institutionalization and if costs are to be controlled.

Studies in the field of gerontology agree that many older citizens would prefer to remain at home but because of their physical or financial limitations, they must be institutionalized if their most basic needs are to be met. Many experts now feel that there should be a stronger community effort to aid the elderly. That includes keeping the aged interested and active and offering special services such as prepared meals and household services. By delaying the institutionalization process as long as possible, we can keep these people from becoming isolated, uninvolved, and no longer an integral part of our communities. Without question the need for alternatives to nursing homes is great.

Presently, the Department of Social Services provides the following alternatives either by direct administration or by contracting these services out, in most cases to the South Carolina Commission on Aging: Day Care for the Elderly, Meals (congregate and home delivered meals), Chore Services, and Transportation. DHEC provides Home Health Care Services for the elderly. Appendix II lists a description of each type of service.

Many of these programs, however, are either just beginning or are reaching a small percentage of the eligible population.

Neither the officials at DSS nor the Commission on Aging could provide a figure on the total number of persons being served by these programs. Also, program officials were unable to tell us the total amount being spent for these alternatives. Currently, there are approximately 53,000 people (23% of the elderly population) who are eligible for Medicaid. If the needs of the elderly are to be met and if costs are to be minimized by avoiding institutionalization, DSS and South Carolina must place greater emphasis on developing and implementing alternatives to nursing homes. According to officials at DSS, Case Managers (social workers) are only now beginning to learn that they should educate potential clients about alternatives.

A Medicaid official at DSS was asked, "Would a person going into a county office to apply to become eligible for a nursing home be told about alternatives to a nursing home?" The response was, "I seriously doubt it. No, they probably wouldn't."

In a study done on alternatives to institutional care for the elderly in South Carolina, the Social Problems Research Institute, U. S. C., concluded the following:

> "There is a pressing need for coordinated, comprehensive, community based services to the elderly. Such a system of service would not only reduce the demand for long term care beds, but would also make it possible for the older person to live a fuller life while residing at home, or in the home of relatives.
>
> Most gerontologists would agree that long term care facilities such as nursing homes are overly utilized in the care of the impaired elderly, primarily because of the lack of community based alternative services."

In its audit of Medicaid, the Legislative Audit Council found not only that DSS was not placing enough emphasis on alternatives to institutionalization but that what did exist appeared to be

poorly coordinated within DSS. In addition, it was discovered that inadequate coordination existed in this area between DSS and other state agencies such as DHEC and the Commission on Aging.

HOME HEALTH CARE

One important alternative to nursing homes that is not being extensively utilized is home health care services. Home health care, administered by DHEC, is perhaps the most well-developed alternative to institutionalization. Yet in FY 76 only one half of one percent of the state's Medicaid budget was spent on home health care.

In addition, DHEC had a surplus of $2.2 million in its home health services account at the end of FY 76. In spite of the availability of these funds, the agency estimated it only served 40% of the individuals who needed this service. These facts are astounding when one considers that this program is far less expensive than nursing homes and allows individuals to stay in their homes and communities. It appears that DHEC has been negligent in providing a needed service when funds were available.

Home health services are designed to help maintain people in a home setting, independent of others for personal care, rather than requiring some form of institutional care. Basically, there are three components of home health care: (1) nursing services, (2) therapy services, and (3) supportive services. All three types of home care services must be based on a physician's plan.

Nursing services, the most often used, include both professional and practical nursing care. There are three types of therapy: physical, occupational and speech. Supportive social

services include medical social workers who help all concerned understand the social and emotional problems related to the patient's health and recovery; and home health aides, who assist patients with such things as bathing, personal grooming, exercising, and walking.

DHEC now provides home health care to individuals in South Carolina including those covered by Medicaid. However, this service is not being extensively used by Medicaid patients. In FY 76, only 2,177 persons used this less expensive but effective care. The average stay for patients in the home health care program in FY 75 was only 138 days for an average cost including medical supplies of $3.29 per day.

The need for home health services was summarized by the U. S. Senate's Special Committee on Aging: "Such programs help those persons, including many older persons, who are ill, but not ill enough to need around-the-clock care at an institution. But if their home care is eliminated, many will be transferred to hospitals or nursing homes simply because there is no other place for them. They will receive the most expensive kind of care simply because more appropriate levels of care are not available."

DEMONSTRATION PROJECTS

The Social Security Act has made provisions which permit states to innovate and develop different projects in an effort to improve programs. Demonstration or pilot projects are allowed if a state obtains a waiver of the Federal Regulations from HEW as authorized by Section 1115 of the Social Security Act. A pilot project could try new approaches at delivering services in one or two counties and if successful apply the approach statewide. A

1115 waiver would allow South Carolina to use Medicaid money and waive the regulations which require that services be offered statewide. An HEW official stated that pilot projects could be used to prevent premature institutionalization of the elderly in nursing homes. Other states such as Texas, Colorado, Wisconsin, and Minnesota have obtained 1115 waivers in developing community care organizations as alternatives for the elderly. The concept here is that someone becomes an ombudsman for the elderly in an attempt to coordinate all of the resources of the federal and state governments to better serve the needs of the elderly.

In 1974 in its report on alternatives to institutional care, the Social Problems Research Institute developed and proposed that South Carolina undertake a Model Program for Community Care for the Elderly. The aim of this program was "the prevention of unnecessary nursing home care." This project, however, never materialized. More than two years after the need for alternatives was clearly cited, there are no serious efforts being made to provide comprehensive, coordinated, alternative services to the elderly.

FOSTER HOME PROGRAM

The aim of a Foster Home Program for the elderly is to provide suitable arrangements for elderly who (either by preference or necessity) should not be living alone, but who neither need nor desire institutional living of any kind. In this program "home-givers" receive payments for providing room and board or a room with kitchen privileges. Foster home programs have been very successful in other states. The program costs less than institutional care and has proven personally rewarding to both parties involved. Development of a Foster Home Program in South Carolina could be an

effective cost-saving program for Medicaid. Here again, DSS has failed to develop a demonstration project to implement such a program.

COST SAVINGS OF ALTERNATIVES

Avoiding the institutionalization of all of the elderly population is an unrealistic goal. But by placing greater emphasis on alternatives as well as establishing and using stringent criteria for placement of persons in nursing homes, institutionalization can be minimized resulting in savings as well as better meeting the needs of the elderly population. Even though portions of the population might well need more than one alternative service (e.g., chore services and home health services), the cost would still be substantially lower when compared to nursing homes. The Social Problems Research Institute study estimated that "as many as 30% of persons who are patients in nursing homes could live in the community if certain basic services were available to them."

Presently, there are approximately 6,000 Medicaid patients in nursing homes. If 30% of these people (1,800) were allowed to return to their community with the support of alternative services, the result could be a substantial savings. If we take a conservative estimate of savings and allow each patient the average amount of home health services now being used plus one additional alternative service daily, then the annual savings would be $8,211,258. This figure was determined as follows:

Nursing Home Patients That Could Return Home		Aver. Yearly Cost for Home Health Services		Aver. Yearly Cost for One Altern. Ser.	Aver. Yearly Cost for an ICF	Total Cost
1800	x				$6,405.75	$11,530,350
1800	x	(453.19	+	$1,390.65)		3,318,912
				Annual Savings (ICF cost less Alternative Service Cost)		$ 8,211,438

Providing the types of services wanted and needed by the eligible elderly population as well as doing it in the most efficient and economical manner possible are the ideal goals of the Medicaid Program. By developing comprehensive and coordinated community based services to the elderly, the spiraling costs of nursing homes can at least be controlled. At the same time, the elderly who would prefer to stay at home will be able to do so.

The success of the alternatives described will take a strong commitment by DSS, DHEC, the Commission on Aging, and the state to promote independent living for the elderly. It remains much easier to institutionalize an individual than to arrange and coordinate an appropriate alternative care program. Many people, including physicians, are unaware of the scope of services available to the homebound elderly individual and feel that proper care can only be provided in an institutional setting. DSS should work toward increasing public awareness of the benefits of alternatives and prompt a greater state commitment to their development, financing and utilization.

RECOMMENDATIONS

- DSS SHOULD EMPHASIZE ALTERNATIVES TO NURSING HOMES AND PROMOTE PLANNING AND COORDINATION OF THE EXISTING RESOURCES IN THE AGENCY AND WITHIN THE STATE. IN ORDER FOR ALTERNATIVES TO BE SUCCESSFUL AND FOR COST SAVINGS TO BE REALIZED, THEY MUST BE IN CONJUNCTION WITH THE ESTABLISHMENT AND ENFORCEMENT OF STRINGENT CRITERIA FOR PLACEMENT OF PERSONS IN NURSING HOMES (SEE P. 27). OTHERWISE WHEN PERSONS LEAVE A NURSING HOME THE AVAILABLE BED WILL BE FILLED. ALTERNATIVE SERVICES MUST BE USED AS A SUBSTITUTE FOR INSTITUTIONALIZATION RATHER THAN AN ADDITIONAL SERVICE.
- DSS SHOULD DEVELOP A PILOT PROJECT FOR THE ALTERNATIVES TO NURSING HOMES. THEY SHOULD SEEK A 1115 WAIVER FROM HEW TO USE MEDICAID MONEY FOR ITS IMPLEMENTATION. THE MODEL PROGRAM DEVELOPED BY THE SOCIAL PROBLEMS RESEARCH INSTITUTE SHOULD BE CONSIDERED IN THIS EFFORT. THE EXPERIENCES OF OTHER SUCCESSFUL STATE PROGRAMS AS IN TEXAS, COLORADO, AND WISCONSIN SHOULD BE BORROWED AND ADAPTED TO SOUTH CAROLINA.
- THE LEGISLATURE MAY WANT TO CONSIDER ADOPTING A STATE POLICY EMPHASIZING ALTERNATIVE METHODS OF CARE FROM NURSING HOMES.

ABUSE OF CARRYFORWARD FUNDS AND THE BUDGET PROCESS

INTRODUCTION

The budgeting, financial, and accounting problems associated with the Medicaid Program are numerous. The program has experienced tremendous expansion over the eight years since its inception, and the problems of funding and accountability have likewise grown considerably. Medicaid is only one of a number of federal programs administered by the department. Several of the programs have different funding requirements and accounting records must segregate expenditures by program and expenditure type. Thus, the situation DSS faces in attempting to manage its financial affairs is one of significant complexity, and no analysis of its financial management of Medicaid can overlook the interrelatedness of programs.

The difficulty of understanding agency finances is underscored by the apparent unreliability of its accounting system. While DSS has not undergone a fiscal audit for either FY 75 or FY 76, each of the two previous audits resulted in the State Auditor disclaiming an opinion on the agency's financial statements. These disclaimers resulted from a lack of adequate internal accounting controls and the absence of proper documentation for agency expenditures. The Council's reviews are not made for the purpose of attesting to agency financial statements. However, the Council had to rely on the information provided by DSS's accounting system.

It was noted that over the last several years, DSS has supplemented its medical assistance appropriation with carryforward funds. The amount of such funds available to DSS has

grown from $455,367 at the end of FY 71 to $10,531,368 at the end of FY 76.

Because of the materiality of the amounts involved in the DSS carryforward, its consistent use to finance Medicaid, and the agency's apparent lack of accountability for its use, the Council elected to examine the origin and the reasons for and effects of the buildup.

CARRYFORWARD FUNDS LEAD TO UNJUSTIFIED BUDGET INCREASES

DSS's carryforward funds have been the major reason why $40,986,513 has been appropriated over the last five years without written justification. The agency's FY 77 appropriation contains $19,342,268 for which no justification has been required in any budget request. Of that amount $10,649,650 has been appropriated to Medicaid. The state's budget system permits agencies having carryforward provisions to obtain increases in their annual appropriations without providing written justification.

If this process continues over several years, an agency can substantially build up its annual appropriation without providing written justification to the Legislature. This is how DSS obtained over $40 million since FY 73 without providing any written justification either to the Budget and Control Board or to the Legislature.

The following table illustrates the buildup within DSS's budget structure of appropriated funds which DSS apparently has never had to justify.

APPROPRIATION INCREASES WHERE WRITTEN JUSTIFICATION
WAS NOT PROVIDED FY 73 - FY 77

	FY 73	FY 74	FY 75	FY 76	FY 77
Tot. Amt. in Cur. Bud. Not Justif.	$555,367	$1,449,063	$7,283,155	$12,356,660	$19,342,368
Cumul. Tot. Not Justif.	$555,367	$2,004,430	$9,287,585	$21,644,245	$40,986,613

See Appendix I for a more detailed analysis.

The presence of these funds, under the current budgeting system, prevents the Legislature from carrying out its oversight function. Each year funds are appropriated to DSS on the basis of distorted, unreliable information; and, in addition to the uncertainty created by such conditions, the Legislature, once it has appropriated these funds, cannot know how much money is to be available to the agency.

The lack of scrutiny has lead DSS to obtain excessive appropriations. One of the most apparent indications that this is so has been the growth over the last six years of the agency's carry-forward fund. Since FY 71, this fund has grown from $455,367 to $10,531,368 at the end of FY 76. The fund increased in five of the last six years to a high of $13,732,325 at the end of FY 75. It decreased in FY 76 only because of the statewide 8% appropriation reduction. The presence of these surplus funds enabled DSS to take its reduction out of money it didn't need instead of

having to make program cuts as did other agencies. The following table shows the buildup of DSS's carryforward funds.

DSS CARRYFORWARD FUNDS FY 72 - FY 77

Year	Amount Carried Into Year	Increase (Decrease) From Previous Year
FY 72	$ 455,367	-
FY 73	2,005,807	$ 1,550,440
FY 74	5,181,642	3,175,835
FY 75	7,237,356	2,055,714
FY 76	13,732,325	6,494,969
FY 77	10,531,368*	(3,200,957)*
Cumulative increase since FY 72		$10,076,001

* Carryforward funds into FY 77 would have been $15,288,071, an increase of $1,555,746, except for the 8% budget cut in FY 76.

Since FY 72, DSS has underspent its appropriation by between $1,500,000 and $6,500,000. But in spite of this, the agency's budget requests for each of those five years have indicated that each year it expected to spend its entire appropriation as well as its entire carryforward. The budget, therefore, has shown base year expenditures to be not only far more than was appropriated but a great deal more than was actually spent and historically more than needed. Appropriation increases were thus concealed each year. In FY 75, state expenditures were estimated by DSS to be $60,886,075. They were in fact $47,153,750. In FY 76 expenditures were estimated to be $67,909,498. They were actually

$57,378,130. This surplus of $13.7 million and $10.5 million, respectively, has given DSS tremendous financial flexibility. Financial flexibility of such magnitude allows an agency to operate virtually independent of the Legislature and the taxpayers.

The state's budgeting system produces an Appropriation Bill each year which conceals the true amount of DSS's requested increase. South Carolina's budget system is "incremental" in nature. That is, the only part of an agency's budget request which it must justify in writing is the amount which exceeds its prior year's appropriation. However, an agency such as DSS which has retained funds from prior years is allowed to add these funds to its prior year appropriation in seeking and justifying additional funds. This means that part of the incremental increase is hidden and written justification is never made for it. An illustration at this point will show the significance and magnitude of this problem.

On page 50, the General Appropriation Act for FY 75-76 has been placed next to the General Appropriation Bill for FY 76-77. Comparison of these two documents will reveal that of the 20 items for which an appropriation was granted by the Legislature in FY 75-76, 12 items were misstated in the General Appropriation Bill for FY 76-77. In addition, 3 items which appear in the FY 76-77 Appropriation Bill cannot be found in the FY 75-76 Appropriation Act.

To further review the significance of such misrepresentation and manipulation, comparing these two documents, let us review two examples which have great impact.

Hidden Personnel Increases

DSS was appropriated 3,802 positions in FY 75-76. This was misstated in the FY 76-77 Appropriation Bill as 4,628, hiding a personnel increase from the Legislature of 826 positions. In the prior budget year, FY 76, DSS similarly hid an increase of 186 positions. Since FY 75, the agency has been allowed to increase its staff by 1,043. However, 1,012 of these have been concealed by misrepresentation and manipulation of data by DSS. This is even more alarming because this occurred during a period when state hiring was supposed to be frozen.

Manipulation of the Medicaid Budget

The $33.8 million in state funds shown as appropriated for FY 75-76 Medicaid costs in the FY 76-77 budget request was found to be inconsistent with the General Appropriation Act for FY 75-76. The Appropriation Act granted them only $20.5 million. Medicaid's actual expenditures for the year were $28.7 million. DSS, at a minimum, should have justified $6.6 million in their budget request for FY 77 ($35.3 million requested for FY 77 less $28.7 million actual Medicaid expenditures for FY 76). However, even this amount would be a misrepresentation because the true incremental increase in state appropriations for Medicaid was $14.8 million ($35.3 million requested for FY 77 less $20.5 million appropriated for FY 76).

> The Legislature passed what appeared to be a $6,111,258 reduction in the Medicaid budget, while, in actuality, it was a $7,211,600 increase. The significance of such misrepresentation is startling. While the increase in the budget request appeared to the Legislature to be a modest 4.4%, it was actually a request for an additional 72.3%.

South Carolina state law requires that the Budget and Control Board submit a budget containing an itemized plan of all proposed expenditures for each state department and that the appropriate amounts for the current and previous appropriation years be shown. Any increase or decrease must also be shown. This is contained in Section 1-727 Code of Laws of South Carolina (1962) as follows:

> §1-727. Budgets submitted to General Assembly. --Within five days after the beginning of each regular session of the General Assembly the State Budget and Control Board shall submit to the presiding officer of each house printed copies of a budget, based on its own conclusions and judgements, containing a complete and itemized plan of all proposed expenditures for each state department, bureau, division, officer, board, commission, institution or other agency or undertaking, classified by function, character and object, and of estimated revenues and borrowings, for each year, beginning with the first day of July thereafter. Opposite each item of the proposed expenditures the budget shall show in separate parallel columns the amount appropriated for the last preceding appropriation year, for the current appropriation year and the increase or decrease. (Emphasis added)

Further, rules have been passed by the House of Representatives to regulate the format and presentation of the annual Appropriation Bill. House Rule 5.3 states that "All State Appropriation Bills shall be printed at each stage in their passage, so as to show the amounts appropriated for any of the purposes therein for the fiscal year immediately preceding...". (Emphasis added) Thus, it would appear that any presentation which deviates from the previous year's actual line item appropriated amounts is in violation of the intent of House Rule 5.3 and State Law 1-727. But in fact the base year amounts appearing in the state's Appropriation Bills were found to vary considerably from actual appropriated figures (See P. 50).

Officials at both DSS and the Budget and Control Board told the Council that the base year figures submitted to the Board are agency estimates. These are the figures which subsequently appear in the Appropriation Bill. This appears to be clearly a violation of House Rule 5.3 and State Law 1-727. The current budget format obscures actual increases in agency budgets thereby materially misleading the Legislature.

The result is that DSS has gained excessive financial flexibility which allows inefficient program management allowing DSS neither to plan nor seek solutions for controlling program costs which would make the programs more manageable. The agency has become practically unaccountable to the Legislature and thus to the taxpayers. The Legislature has the right to expect total accountability and justification for all budget increases from an agency.

It is inefficient and ineffective to permit agencies to manipulate historical data in order to avoid having to explain budget increases. But the state's current budgeting process does not prevent such abuse.

GENERAL APPROPRIATION ACT FOR FY 75-76

SECTION 45

DEPARTMENT OF SOCIAL SERVICES
(Budget Reference: Volume II, Page 1121)

I. Administration and Program Services:	
rsonal Service:	
Commissioner (1)	$ 33,320.00
Classified Positions (3802)	12,706,494.00
Other Personal Service:	
Temporary/Part-time Help	109,110.00
Contractual Services	2,714,845.00
Supplies	559,000.00
Fixed Charges & Contributions	862,280.00
Equipment	341,340.00
Fees for Service	2,825.00
Case Services and Public Assist. Pmts.	104,000.00
Special Projects - Day Care Centers:	
Personal Service (117)	73,979.00
Operating Expenses	33,579.00
Total (Administration & Prog. Service)	$17,540,772.00
em II. Assistance Payments:	
Aid to Families w/Dependent Children	$15,322,064.00
General Assistance	1,919,560.00
Medical Assistance (Medicaid-Title XIX)	20,500,400.00
Foster Home Care	1,451,500.00
SSI Supplementation Program	279,021.00
Operation of Day Care Centers	720,600.00
Patients-Mental Health Commission	775,675.00
Patients-Department of Health and Environmental Control	51,000.00
Medical Payments for Phys. Ment. Handicapped Children	12,500.00
Total (Assistance Payments)	$41,032,320.00
OTAL (Dept. of Social Services	$58,573,092.00

GENERAL APPROPRIATION BILL FOR FY 76-77

SECTION 45

Department of Social Services

(Budget Reference: Volume II, Page 1217)

	1975-76	1976-77						
	State Funds Appropriated (1)	State Funds Requested (2)	B & C Board Recommendation Total Funds (3)	B & C Board Recommendation State Funds (4)	Ways and Means Bill (5)	Passed by House (6)	Approved, Senate Finance Com. (7)	Passed by Senate (8)
Item I. Administration and Program Services:								
Personal Service:								
Commissioner	$ 33,320.00 (1)	$ 35,000.00 (1)	$ 33,320.00 (1)	$ 33,320.00 (1)	$ 33,320.00 (1)	$ 33,320.00 (1)	$ 33,320.00 (1)	$ 33,320.00 (1)
Classified Positions	13,332,152.00 (4,628)	13,935,595.00 (4,696)	40,748,501.00 (4,659)	13,833,949.00 (4,659)	13,833,949.00 (4,659)	13,833,949.00 (4,659)	13,833,949.00 (4,659)	13,833,949.00 (4,659)
Other Personal Service:								
Temporary/Part-time Help	65,237.00	85,184.00	250,000.00	85,184.00	85,184.00	85,184.00	85,184.00	85,184.00
** Per Diem—Boards & Commissions	806.00	806.00	2,000.00	806.00	806.00	806.00	806.00	806.00
Contractual Services	3,144,706.00	3,441,310.00	31,054,488.00	3,399,135.00	3,399,135.00	3,399,135.00	3,399,135.00	3,399,135.00
Supplies	760,130.00	834,325.00	2,339,386.00	833,437.00	833,437.00	833,437.00	833,437.00	833,437.00
Fixed Charges and Contributions	741,609.00	756,400.00	1,876,753.00	751,000.00	751,000.00	751,000.00	751,000.00	751,000.00
Equipment	600,669.00	303,216.00	773,215.00	282,481.00	282,481.00	282,481.00	282,481.00	282,481.00
Fees for Service	1,314.00	1,314.00	3,500.00	1,314.00	1,314.00	1,314.00	1,314.00	1,314.00
** Aid to Counties	1,717.00	1,717.00	4,500.00	1,717.00	1,717.00	1,717.00	1,717.00	1,717.00
Case Services and Public Assistance Payments	153,043.00	187,109.00	936,156.00	187,109.00	187,109.00	187,109.00	187,109.00	187,109.00
Employer Contribution	.....	.....	3,125,613.00	.....	.....	.....	.....	.....
Purchase of Evidence	.....	497.00	1,000.00	497.00	497.00	497.00	497.00	497.00
Total (Administration and Program Services)	$18,854,703.00	$19,582,473.00	$81,148,432.00	$19,409,949.00	$19,409,949.00	$19,409,949.00	$19,409,949.00	$19,409,949.00
Item II. Assistance Payments:								
Aid to Families with Dependent Children	$15,322,064.00	$17,900,256.00	$53,413,238.00	$14,606,711.00	$14,506,711.00	$14,506,711.00	$14,506,711.00	$14,506,711.00
General Assistance	1,919,560.00	2,634,816.00	1,714,632.00	1,714,632.00	1,714,632.00	1,714,632.00	1,714,632.00	1,714,632.00
Medical Assistance (Medicaid-Title XIX)	33,823,255.00	35,339,736.00	106,065,145.00	27,512,617.00	27,512,617.00	27,512,617.00	27,512,617.00	27,712,000.00
Foster Home Care	1,451,500.00	2,340,000.00	1,368,000.00	1,368,000.00	1,468,000.00	1,468,000.00	1,468,000.00	1,468,000.00
SSI Supplementation Program	279,021.00	42,302.00	19,809.00	19,809.00	19,809.00	19,809.00	19,809.00	19,809.00
Development, Equipment and Operation of Day Care Centers	86,920.00	705,597.00	86,920.00	86,920.00	86,920.00	86,920.00	86,920.00	86,920.00
Indo-China Refugee Assistance	.....	.....	880,992.00	.....	.....	.....	.....	.....
Food Stamps Issued	.....	.....	200,960,071.00	.....	.....	.....	.....	.....
Patients—Mental Health Commission	775,675.00	1,677,670.00	5,206,998.00	1,375,689.00	1,375,689.00	1,375,689.00	1,375,689.00	1,525,689.00
Patients—Department of Health and Environmental Control	51,000.00	52,840.00	164,001.00	43,329.00	43,329.00	43,329.00	43,329.00	43,329.00
Med. Pmts. for Phys.-Ment. Handicapped Children	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00	12,500.00
** Adult Protective Services	90,000.00	90,000.00	90,000.00	90,000.00	90,000.00	90,000.00	90,000.00	90,000.00
Total (Assistance Payments)	$53,811,498.00	$60,795,717.00	$369,982,306.00	$46,830,207.00	$46,830,207.00	$46,830,207.00	$46,830,207.00	$47,179,590.00
Increments	.....	411,907.00	.....	.....	.....	.....	.....	.....
Appropriation Reduction by Budget and Control Board	(4,756,703.00)	.....	.....	.....	.....	.....	.....	.....
TOTAL (Department of Social Services)	$67,909,498.00	$80,790,097.00	$451,130,738.00	$66,240,156.00	$66,240,156.00	$66,240,156.00	$66,240,156.00	$66,589,539.00

* The appropriation for these line items are misstated in the FY 76-77 Appropriation Bill.

**These line items were not appropriated by the General Assembly in FY 75-76.

STATE'S CURRENT BUDGET PROCESS MISREPRESENTS ACTUAL CHANGES IN AGENCY FUNDING

DSS is not entirely at fault in the misrepresentation of its budget. The Budget and Control Board must take some of the responsibility. Budget and Control Board officials indicated that they considered this a major problem in the current budgetary system which deserves the immediate attention of the Legislature. DSS took advantage of the state's budget format which does nothing to prevent this from occurring. However, an agency can and should present the clearest possible picture of its activities to the Legislature.

DSS, therefore, must take most of the responsibility. The figures shown as base year expenditures in the annual budget requests are estimates prepared by the agency's budget section. They are what the agency is telling the Legislature it expects to spend during the current year.

The system currently requires agencies to submit an annual budget request prepared in accordance with the Budget and Control Board's Budget Preparation Manual. This manual requires that agencies provide written justification by line item (that is, by type of expenditure) for any requested increases in state funds. It requires that an agency show by line item the estimated total amount of funds it has for the current or "base" year as well as the amount of such funding to be derived from state appropriations. Any increase from the "state appropriation" amount must be justified by line item.

The manual also requires, however, that "the columns headed 'State Appropriations' should include that part of 'total funds' derived from state sources, including any carryforward state appropriations". (Emphasis added) This requirement is emphasized because it is precisely this rule which permits DSS to obtain increases in its appropriation without showing justification in the budget request. The inclusion of these carryforward amounts conceals budget increases.

The carryforward funds can be spent almost without restriction. Section 71-76 of the 1962 Code of Laws of South Carolina provides that:

> Any unexpended balance remaining to the credit of any fund (...of the Department of Social Services) at the end of any month, year or other period shall not revert to the State Treasury but shall remain in the respective fund subject to future use by the State Department for the purposes originally provided. (1962 Code § 71-16; 1942 Code § 4996-13; 1937 (40) 496.) (Emphasis Added)

In each year since FY 74, the Appropriation Act has altered this provision to give DSS more discretion over the use of such "carryforward" funds. The FY 74 and FY 75 Acts provided that the funds carried into those years could be "allocated with the approval of the Budget and Control Board to the various operations of the department." (Emphasis added) The FY 76 and FY 77 Acts restrict the agency from carrying forward personal service funds but otherwise provide DSS the same expanded latitude in the use of its carryforward money.

Thus, each year since FY 74 DSS has been granted an unknown amount of money to be spent as the agency sees fit. And each year this money has distorted the historical appropriation data of the budget documents, permitting DSS to obtain funds without giving an explanation of the need. Thus, unneeded appropriations have been granted, the money has been unspent and has been carried forward. The result is that the Legislature has lost its oversight control over the agency.

If DSS had no carryforward provision much of the distortion present in its budget request would be eliminated. It was the presence of $13,732,325 in carryforward funds for FY 76 which permitted DSS to overstate its Medical Assistance Appropriation for FY 76 by over $13,000,000. The carryforward provision is an outdated budgeting mechanism causing distortion in budget requests and undermining the Legislature's function of oversight and review of state programs. An official of the Budget and Control Board said that the inclusion of carryforward funds in the Appropriation Bill forces the Board to make budget recommendations in an almost arbitrary manner.

The power of the Board to recommend budget cuts is apparently its main tool to be used to counter the effect of this kind of distortion. It is inefficient to permit the budget request to be misleading and then to attempt to correct the misrepresentations afterward. This is especially important when the corrections must be made arbitrarily.

EFFECT OF DSS'S CARRYFORWARD FUNDS AND BUDGET MANIPULATION

Since FY 73, the budget process has permitted DSS to obtain $40,986,513 in state funds without submitting written justification in its budget request. Of that amount $17,370,672 was money used in Medicaid. Over 60% of its budget increases since then have been obtained without justification in the request.

Concealed increases in the Appropriation Act have occurred because DSS has been allowed to include carryforward funds as part of the current appropriation. Also, DSS has listed estimated expenditures, many times very inaccurate, instead of the actual amount appropriated. These inconsistencies with the law led to inaccurate and distorted budget information being given to the Legislature resulting in the Legislature being unable to accurately oversee and control state spending.

Additionally, this money provides DSS with excessive financial flexibility. DSS has been able to distort the true picture of the Medicaid program by using carryforward funds in its budget request. For example, in FY 76, DSS was appropriated $20,500,400 for medical assistance payments. The agency actually spent approximately $28,700,000 on such payments. If not for the carryforward fund, the agency would have been forced to seek additional funding from the Legislature. The state would have had to face the facts of increasing Medicaid costs and would have had to seek solutions. The agency would have had to manage costs more effectively and perhaps long ago would

have found it necessary to implement an effective information system. Some of the problems the program now faces might have been solved if DSS had had less unrestricted carryforward money and thus been compelled to be efficient managers.

Examples of DSS's budget misrepresentation and manipulation under the current budget system were found to be numerous. To illustrate, for contractual services, DSS's FY 75 appropriation was $1,945,526. In the FY 76 budget request the agency estimated that it would spend $2,481,766 in FY 75 and requested $2,770,357 for FY 76. In the Appropriation Bill the change in state funds appears to be only $288,591, but in fact the agency was requesting an increase of $824,831. The agency's carryforward funds when added to the actual appropriation concealed $536,240 of the budget increase, since this amount did not have to be justified.

No record was found which would indicate that DSS in fact had to justify this increase before a committee of the Legislature; but, in FY 75, the agency's state expenditures for contractual services totaled only $1,330,776. This is $614,750, 31.5%, less than they were appropriated and $1,150,990, 46.3%, less than their estimates.

These estimates are submitted almost one third of the way through the base year. It is incomprehensible that management should project expenditures so inaccurately.

Each year the agency has estimated spending far more than it in fact has spent. The effect is to minimize the amount of

written justification which DSS must present. This trend leads the Council to challenge the reliability of the agency's requests, if not to question its motives.

RECOMMENDATIONS

- THE LEGISLATURE SHOULD ELIMINATE DSS'S CARRYFORWARD PROVISION AND ALL SUCH FUNDS ACCUMULATED BY DSS SHOULD BE RETURNED TO THE GENERAL FUND.
- THE BUDGET AND CONTROL BOARD SHOULD REVISE ITS BUDGET PROCESS AND BUDGET MANUAL SO THAT AGENCY BUDGET REQUESTS AND THE APPROPRIATION BILL WILL SHOW THE PRIOR YEAR'S APPROPRIATION EXACTLY AS IT WAS PASSED BY THE LEGISLATURE. ALL CHANGES FROM THE APPROPRIATION ACT AS PASSED BY THE LEGISLATURE SHOULD BE CLEARLY VISIBLE IN A SEPARATE COLUMN AND JUSTIFIED IN WRITING.
- THE FY 76-77 APPROPRIATION ACT REQUIRED THAT COMPLETE JUSTIFICATION BE PROVIDED FOR EACH AGENCY'S BUDGET REQUEST BEGINNING IN FY 77-78. DSS SHOULD BE REQUIRED BY THE LEGISLATURE AND THE BUDGET AND CONTROL BOARD TO PROVIDE COMPLETE WRITTEN JUSTIFICATION FOR ALL FUNDS IN ITS FY 77-78 BUDGET REQUEST.

LACK OF AN ADEQUATE MANAGEMENT INFORMATION SYSTEM

DSS does not have an adequate management information system to efficiently process claims and to provide the information needed to effectively manage the Medicaid Program. This has resulted in a less than effective utilization review and surveillance of health services and a lack of wise and timely policy decisions. Also, an effective management information system could possibly have saved as much as $4 million in program costs last year. There is a need for controls over eligibility, prices, utilization, and expenditures. The size, cost and complexity of the Medicaid Program requires a comprehensive, automated management information system for efficient administration.

Concern over rapidly rising Medicaid costs and inflation in the health field led HEW to develop an effective Medicaid Management Information System (MMIS) in 1971. The objective of MMIS is to improve the capability of the state agency in administering the Medicaid Program. The MMIS is a computerized system designed to effectively process and control claims and to provide management with the necessary information for planning and control. It is composed of six functional areas or subsystems which include a claims processing subsystem, surveillance and utilization review subsystem, and a management and administrative reporting subsystem. HEW encourages states to develop and install data processing systems based on the model MMIS, by reimbursing the state 90% of the development costs (retroactive to the date the plan is submitted to HEW) and 75% of the cost of operating the system. DSS now

receives a matching rate of 50% from HEW for the data processing operating costs related to Medicaid.

Currently claims processing is divided between DSS and Blue Cross/Blue Shield. Blue Cross/Blue Shield processes the claims from doctors, dentists, optometrists, opthamologists, podiatrists, laboratories, ambulance providers and vendors of durable medical equipment. These claims account for approximately 19% of the total Medicaid dollars. DSS processes claims for all other programs which include inpatient and outpatient hospital claims, drug claims, and nursing home payments. These amount to approximately 85% of the total Medicaid dollars. Blue Cross/Blue Shield's processing system has some of the same components as the HEW model MMIS, but DSS's system is not similar.

The need for an effective MMIS in South Carolina has been known since 1971. In November 1971, HEW's Division of Management Information and Payment Systems undertook a MMIS survey and analysis for South Carolina and the Department of Public Welfare. The resulting report made specific recommendations for changes and improvements, with supporting cost and schedule estimates for the implementation of all or portions of the MMIS, tailored to South Carolina's needs. The total estimated cost to develop and install the system would have been $379,000.

The HEW Audit Agency, in an audit report in January 1973, stated that DSS needed to implement an effective prescribed drug utilization review system designed to detect and minimize over-utilization of this service. The recommendation was for recipient profiles to be developed in the drug program. DSS Commissioner's

reply was that "when the Medicaid Management Information System is operational this will expand utilization procedures by computer input for evaluation by the professional staff." However, more than 3½ years later there is still no MMIS in existence.

In 1973, DSS submitted an Advance Planning Document to HEW to alert them of South Carolina's intent to claim the federal financial participation for design of a MMIS. DSS, however, did not get beyond this stage in designing and implementing a system.

In November 1975, DSS's Medical Assistance Division Chief advocated the implementation of MMIS and recommended that a consultant's proposal to prepare a MMIS Advance Planning Document for presentation to HEW be approved. In a memo to the Commissioner, he stated that the MMIS provides the means to accomplish the objective of improving the capability of DSS to administer the Medicaid Program efficiently and effectively.

For a program as complex, expensive, and rapidly growing as Medicaid, adequate controls and information systems are vital if the program is to be administered as efficiently and effectively as possible. DSS has been plagued with problems in processing claims, determining eligibility, and utilization review since South Carolina began participating in Medicaid in 1968. The drug claims processing system produces frequent overpayments and allows payment of duplicate claims (see p. 79). A recent review by DSS of only a small percentage of claims for eligibility errors found that 30% of the cases found to be ineligible were due to system errors.

The lack of a MMIS has greatly hampered the effectiveness of the agency's utilization review of services. The existing system is unable to generate needed reports and is not sufficiently flexible to meet changing needs for information. Data processing is unable to generate recipient and provider profiles as required by HEW regulations which would be used in utilization review. A recipient or patient profile is a history of all the services (such as operations, physician visits, and drugs) that an individual has received under the program. A provider profile is a history of all the services that an individual provider has provided under the program. An efficient effective system should take these profiles and routinely compare them with certain standards and report the exceptions for utilization review.

The lack of a MMIS has resulted in DSS being without the information needed for making wise and timely program policy decisions and for controlling costs. For example, DSS provided its State Board a list of possible limitations to the services now provided under the Medicaid Program. However, there was a lack of information to make accurate projections of the effect of these proposed limitations on the recipients, providers and the budget.

The combined effects of increasing eligibility, the use of services, and the rising cost of the services themselves have led DSS to foresee a financial crisis in the Medicaid Program. In May 1976, DSS activated its Medical Care Advisory Committee, composed of provider representatives from each program to establish priorities. This committee, although required by Federal Regulations and the Medicaid State Plan, had not met in three years.

From these provider representatives, DSS requested program information such as the population need for services, potential eligibles for service, utilization of services by eligibles, growth in cost of services, etc. This type of data should have been available within DSS since it is administering the program, but it does not have the information system to do the job. Thus, the agency must find ways to cut program costs, and it must base its decision, in part at least, on information provided by parties who will be hurt by cost cutting.

Besides promoting efficient claims processing and effective surveillance and utilization review to control overutilization, the MMIS generates a number of management and administrative reports. These reports furnish information to the state agency to support management review, evaluation, and the planning/decision making process; to assist in the development of improved medical assistance program policies and regulations; and to provide management with financial data for proper fiscal planning and control.

In the past, the existence of ample carryforward monies to fund the Medicaid Program has allowed DSS not to emphasize cost control and efficient program administration. This is evident in the agency's hesitancy in developing an efficient management information system in which the federal government would reimburse the state 90% of its development cost. The advantages of better control and administration of the Medicaid Program warrant the investment in a MMIS. HEW officials estimate that as much as 4% of Medicaid expenditures can be saved in any state by a MMIS. In

South Carolina this would mean an annual savings of over $4 million. These savings can be captured by collecting from third party insurers, controlling utilization, and deterring fraud.

The MMIS could result in a savings of state funds used for its operation. In FY 76 the cost of DSS's in-house data processing for Medicaid and the claims processing contract with Blue Cross/Blue Shield amounted to $1,441,797. The federal government reimbursed DSS for 50% of these costs or $720,898. The federal reimbursement with an HEW approved MMIS is 75% of the system's operating costs. Even if the total operating costs for the MMIS are more than is presently being spent, a system could be operated costing as much as $2,883,592 for the same amount of state dollars. If the system cost less than this, it would result in savings to the state. For instance, if an HEW approved MMIS had been in place in FY 76 and the operating costs were the same as was spent in that year, the state would have saved $360,449. This would have been more than enough money to pay the state's share for development and implementation of a MMIS. However, it must be emphasized that the real benefits are in a more effective and efficient administration of the Medicaid Program. The benefit from better review of claims and payments will be much greater than the cost of the system.

DSS has been plagued with data processing problems for many years. They have again begun work in developing an information system that will include an eligibility subsystem, a financial subsystem and a MMIS. Since the delivery of services has been so wasteful and poorly managed partially because of the lack of a MMIS, it is imperative that DSS carry through with the project as

expeditiously as possible this time. However, an Advance Planning Document is not expected to be ready for submission to HEW until May 1977 and DSS did not follow through on its previous commitment to the development of a MMIS. Also, DSS expects the entire project to take at least three years to develop. This raises doubts whether current staff can successfully implement the MMIS project. The importance of a MMIS requires sufficient and competent personnel to staff and manage the project, if project tasks are to be completed on schedule.

South Carolina is a late comer among states in beginning initial plans for development of a MMIS. Starting late can only be an advantage if DSS capitalizes on the mistakes of its predecessors. One example which seems universal among those states which have implemented Medicaid Management Information Systems is the ineffective use of the surveillance and utilization reports produced by the system. South Carolina should be able to profit from the experiences of states such as Michigan, Ohio, and New Mexico where MMIS has been very successful. Also, this project will require close cooperation with federal officials to obtain funding and to avoid unnecessary delays.

The presence of a MMIS in itself is not a cure-all for the problems besetting Medicaid. Management must be committed to using the system to more effectively administer the program. This means having a sufficient number of qualified individuals to take the reports generated and thoroughly investigate areas of abuse and overutilization. It means having managers who are capable of using the management and financial reports to make proper program and

policy decisions. In essence, the most sophisticated data processing system is worthless if management will not use it. The MMIS can help DSS properly administer Medicaid, and the Council urges that the agency commit itself to this objective.

RECOMMENDATIONS

- THE DEVELOPMENT OF THE MMIS SHOULD BE GIVEN HIGH PRIORITY WITH FUNDS AND STAFF COMMITTED FOR THIS EFFORT IN ORDER TO IMPLEMENT THE SYSTEM AS QUICKLY AS POSSIBLE.
- DSS SHOULD SET UP A TASK FORCE WITH A QUALIFIED PROJECT DIRECTOR FOR DEVELOPING A MMIS PROPOSAL TO BE PRESENTED TO HEW FOR FEDERAL FINANCIAL PARTICIPATION.
- A PROJECT MANAGEMENT SYSTEM SHOULD BE USED TO HELP SCHEDULE, CONTROL, AND MONITOR MMIS PROGRESS. THE MAGNITUDE OF A MMIS PROJECT REQUIRES THAT DSS HAVE A PROJECT MANAGEMENT SYSTEM TO HELP SCHEDULE, CONTROL, AND MONITOR MMIS PROGRESS. THE COMPLEXITY OF SUCH AN IMPORTANT PROJECT REQUIRES THAT THERE BE CONTINUOUS SURVEILLANCE. THIS SYSTEM WILL AID PROJECT MANAGERS IN RECOGNIZING AND AVOIDING UNNECESSARY DELAYS BEFORE THEY OCCUR. IN ADDITION, THE SYSTEM WOULD PROVIDE INFORMATION REQUIRED FOR HEW MONITORING AND LEGISLATIVE OVERSIGHT.
- TO THE GREATEST EXTENT POSSIBLE, DSS SHOULD BORROW FROM OTHER STATES SUCH AS MICHIGAN, OHIO, AND NEW MEXICO WHERE A SUCCESSFUL MMIS HAS BEEN IMPLEMENTED.
- HEW TECHNICAL ASSISTANCE SHOULD BE UTILIZED AND A CLOSE WORKING RELATIONSHIP MAINTAINED.

INADEQUATE UTILIZATION REVIEW AND CONTROL SYSTEM

DSS's utilization review and control system is not adequately developed to allow DSS to effectively control the use of the Medicaid services. In order to take appropriate corrective measures in cases involving overuse of services, the cases have to be known. DSS cannot recognize trends and patterns of the utilization of services or identify the causes of improper utilization.

Utilization review and control is the system used to determine the appropriateness of medical care provided and to identify and prevent overutilization of medical services. Utilization review has two basic purposes; to help ensure that individuals receive high quality medical care and to control program costs by preventing unnecessary use. The skyrocketing costs of the Medicaid Program from $34.5 million in FY 71 to over $109 million in FY 76 has been caused by inflation, increasing eligibility roles and increased utilization of services. Without an adequate utilization review and control system there is no way to determine if Medicaid is working. Regardless of how well intended program administrators might be, they have failed if they are unable to control costs and determine the appropriateness of medical care provided to the needy.

Section 1902 (a) (30) of the Social Security Act requires states to have methods and procedures to review the utilization of care and services provided under the State Medicaid Plan to safeguard against unnecessary utilization. HEW's implementing regulations require South Carolina to have statewide surveillance and utilization control systems to safeguard against unnecessary

or inappropriate utilization of the care and services provided under Medicaid and to provide a basis for assessing the quality of these services. The utilization review system must provide for continuous review of care and services which includes an on-going evaluation, on a sample basis, of the necessity for and quality of these services and a postpayment review process. The review process includes the development and review of recipient utilization profiles, provider service profiles, and exceptions criteria; and identifies exceptions in order to rectify misutilization practices of recipients, providers, and institutions.

NONUTILIZATION OF PROVIDER AND RECIPIENT PROFILES

With the exception of provider profiles used by Blue Cross/Blue Shield, neither recipient utilization profiles nor provider service profiles are developed or used by DSS as required by HEW regulations. Recipient and provider profiles are used to identify recipients and providers deviating by specified margins from designated standards so that appropriate corrective action can be taken. Recipient profiles would list all of the services provided to a particular patient during a specified period of time and would be used to detect if a patient were misutilizing services. For example, patient profiles could spot persons who are being treated for the same diagnosis by several doctors, getting duplicate prescriptions, or receiving treatment and medication which deviates from the expected treatment or the diagnosis.

Provider profiles are statistical summaries of the pattern of practice of the provider whether it is a physician, a hospital, or the medical experience of a specific population. These profiles

would detect when a physician's treatment pattern deviates significantly from his peer group. An example would be a physician who administered a shot or a series of tests to every Medicaid patient who walked in the door. This is the type of analysis which must be done to effectively control the use of Medicaid services and ensure that the recipients are getting the quality of care they need. Blue Cross/Blue Shield uses provider profiles to help identify physicians who are potentially abusing the services. However, DSS does not use provider profiles in any of the programs it administers and neither are recipient profiles used.

Another report that is used in an effective utilization control system is a treatment analysis report. This report facilitates an analysis of the level and quality of care rendered by individual providers of physician and inpatient hospital services. It allows the Medicaid staff to pick up suspicious diagnosis/treatment/prescribing practices even if billing procedures seem to fit into the pattern of the participant's peers. Again, DSS and Blue Cross/Blue Shield do not use this type of analysis in its utilization review of Medicaid services.

On November 11, 1970, HEW issued an audit report on South Carolina's Medicaid Program as well as a follow-up report in December 1972 on DSS's implementation of the report's recommendations. Both audit reports found vendors and recipient history profiles were not maintained in the drug program resulting in a lack of data to evaluate trends and detect abuses. DSS concurred with HEW's recommendation "that necessary recipient profiles be established as soon as possible" and agreed with the necessity of these profiles. However, more than three years later DSS has not implemented these recommendations.

DSS officials told the Council that recipient and provider profiles and other statistical reports are not routinely generated because of the lack of an effective management information system. To be effective, the utilization review system has to be closely tied to the claims processing system to detect improper utilization of services. It also must be coordinated with the investigation of potential fraud and abuse. Blue Cross/Blue Shield does this in its work with physician claims, but DSS's claim processing of hospital and drug claims is not sophisticated enough to do this. For example, "diagnostic edits" are not run on hospital claims. This would be an examination by the computer of the treatment as indicated on the claim to eliminate improper claims. In the current system, a claim for a male receiving a hysterectomy or a person having an appendectomy which had already been performed by another hospital could be processed and paid.

An effective utilization review system, including recipient and provider profiles, is necessary if DSS is to provide a continuous, ongoing evaluation of the necessity for and quality of services provided. Without such a system DSS cannot even detect the abuse or overutilization of services, much less control them.

REVIEW OF HOSPITAL CLAIMS NEEDS TO BE EXPANDED

DSS's limited utilization review of hospital claims has been effective, but improvements need to be made to expand this review of claims. DSS reviews a small selection of inpatient, outpatient hospital claims in a manual operation consisting of two persons. Two nurses review inpatient hospital claims dealing with sterilization and abortion, chronic renal dialysis, elective surgery, out-

of-state claims, all inpatient claims over $5,000, and all outpatient claims over $100. In FY 76, they reviewed approximately 24,000 hospital claims denying 220 for a savings of $106,133. If this much money can be saved on a manual operation with just two persons, then one can only speculate how much would be saved if an automated system reviewing all claims were used. In FY 76 DSS processed 38,201 inpatient hospital claims and 138,588 outpatient claims with payments of $26.4 million and $3.7 million respectively. Screening techniques could be used to identify claims representing overutilization of services such as: stays beyond the median stay for the diagnosis which are not justified by secondary diagnoses and operations; short lengths of stay with high lab and x-ray charges but with low drug and other therapeutic charges which are more likely to represent unnecessary "diagnostic" admissions; delays between the time of admission and the performance of surgery; and admissions for non-covered physical therapy, dental care, cosmetic surgery, excluded foot care, Workmen's Compensation cases, sterilizations, etc.

It is impossible to say how much an effective utilization review system could save the Medicaid Program. However, looking at what DSS has done with a manual operation consisting of only two persons reviewing a small selection of hospital claims the savings could be substantial. More important, without an effective utilization review system DSS cannot recognize long term trends in utilization patterns or identify the underlying causes of improper utilization. This is needed to formulate effective policies to control the program and assure that appropriate medical care is given to the needy.

RECOMMENDATIONS

- THE REVIEW OF HOSPITAL CLAIMS SHOULD BE EXPANDED. ALSO WITH THE IMPLEMENTATION OF A MMIS, RECIPIENT AND PROVIDER PROFILES AND OTHER MANAGEMENT REPORTS SHOULD BE DEVELOPED AND USED TO CONTROL OVERUTILIZATION OF SERVICES, RECOVER MISSPENT MONIES, AND FOR ANALYSIS OF THE QUALITY OF CARE GIVEN TO THE PEOPLE SERVED. TRENDS IN UTILIZATION PATTERNS AND CAUSES OF IMPROPER UTILIZATION OF SERVICES HAVE TO BE IDENTIFIED AND APPROPRIATE CORRECTIVE MEASURES TAKEN.

FAILURE TO COLLECT PROVIDER OVERPAYMENTS

Since April 1975, Blue Cross/Blue Shield, DSS's Medicaid Fiscal Agent, has found $146,314.53 in overpayments to Medicaid providers through its provider investigations. Of this amount, $129,983.04 (89%) was still outstanding as of October 1976. DSS has not collected this money nor have they taken administrative sanctions or legal action against any of the providers.

Every state agency is responsible and accountable for the proper administration of all of its programs. Failure to collect the Medicaid overpayments is another indication of inadequate management in DSS. DSS's failure to collect the $129,983.04 in Medicaid overpayments has resulted in the inefficient use of state and federal resources. In addition to the loss to the program's recipients, the federal government could require South Carolina to refund the federal share of these overpayments, approximately 75% or $97,487. South Carolina is liable whether DSS collects the money or not.

The more important effect of noncollection, however, is to undermine the entire provider review process. The purpose of the review is to deter provider abuse. Noncollection prevents the reports from having any impact necessary to achieve this. For example, there are ten providers who have been audited twice and found to have been overpaid both times, and yet they have not refunded any money to DSS.

Each year, since September 1974, Blue Cross/Blue Shield, (BC/BS) in conjunction with DSS, has selected between 40 and 60 providers for audit. The basis for selection is a set of "screens"

employed by BC/BS to isolate (1) providers whose claims suggest unusual patterns of treatment and (2) providers whom Medicaid has paid more than a certain dollar amount. These providers are considered statistically "aberrant" since their practices deviate from their peer group. After the selection process is complete, BC/BS sends teams into the field to examine the records of these providers. The purpose of this examination is to determine the existence and amounts of overpayments to these providers.

When an overpayment is determined to exist, BC/BS notifies the provider by means of a form letter which requests the provider to submit to BC/BS a check made out to DSS. This letter states:

> "Failing to liquidate the overpayment within fifteen days from the date of this letter, we are required to notify you of our intention to recover this amount by offsetting Medicaid benefits which would normally be paid to you on future assigned cases. However, you may submit any statement (including any pertinent evidence) as to why the carrier should not put into effect this recoupment action. If the overpayment is not liquidated, or if no statement is received, the recoupment action will go into effect as stated above."

The Medical Assistance Division receives notices from BC/BS when the fifteen day waiting period has expired. The notification requests that DSS begin the offset procedure and in effect places the responsibility for collection on DSS.

To date, Blue Cross/Blue Shield has identified 20 providers who have been overpaid a total of $146,314.53. Only $16,331.49 has been refunded. Officials in the Medical Assistance Division have not been given the authority to initiate the recoupment procedure. One physician owes the state more than $28,000 and nine other providers owe between $5,000 and $12,000 each.

In a memorandum on this subject dated November 26, 1975, the Medical Assistance Division, Operations Branch Director asked the Deputy Commissioner, Bureau of Assistance and Field Operations, "Does the executive committee wish to approve or reject our deducting these amounts [overpayments to providers] from subsequent payments?" The memo closed stating that, "all actions will be held in abeyance until further advice from you." As of October 6, 1976 ten months after this memorandum, recoupment procedures still have not been initiated.

RECOMMENDATIONS

- DSS SHOULD IMMEDIATELY INITIATE THE PROCEDURE OF OFFSETTING CURRENT MEDICAID PAYMENTS TO PROVIDERS WHO HAVE NOT REFUNDED THE OVERPAYMENTS. IF LEGAL ACTION IS NECESSARY TO RECOUP THE FUNDS, IT SHOULD BE TAKEN.
- PROVIDERS WHO ARE FOUND TO CONTINUALLY ABUSE THE PROGRAM SHOULD BE TERMINATED OR SUSPENDED FROM THE PROGRAM.
- DSS SHOULD INSTRUCT BLUE CROSS/BLUE SHIELD TO INITIATE INVESTIGATIONS OF PRIOR YEARS FOR PROVIDERS WHO HAVE RECEIVED LARGE OVERPAYMENTS.

LACK OF INVESTIGATION FOR FRAUD AND ABUSE

At the national level, HEW estimates that provider fraud and abuse are siphoning off up to $750 million annually. State efforts to stop Medicaid fraud have been meager, with too few staff or funds to do the job. Although DSS has been participating in the Medicaid Program for eight (8) years, the Department of Social Services does not yet have an Office of Investigation which their officials define as "operational". HEW regulations require DSS to maintain methods for identifying fraud. South Carolina has never convicted either a provider or a recipient for fraud in the Medicaid Program. HEW officials estimate fraud and abuse in South Carolina could have amounted to as much as $5 million in FY 76 alone. South Carolina also does not have a state statute for prosecution of providers who submit fraudulent claims. Since June 1974, when DSS began reporting statistics on Medicaid fraud to the National Center for Social Statistics, only six cases have been reported. One case has been referred to law enforcement officials while the other five were dropped because of insufficient evidence.

In October 1975, DSS assigned two employees to plan and set up an Office of Investigation to investigate fraud in all programs administered by DSS. This office became permanent in May 1976 but it is not yet considered operational. For the ten months preceding the establishment of this office, DSS had a "Program Integrity Section" within the Medical Assistance Division which was manned by one person. According to officials within DSS, the main reason the section was established was so the agency would be in compliance with Federal Regulations.

Section 250.80 of the Federal Regulations require that DSS "establish and maintain methods and criteria for identifying situations in which a question of fraud in the program may exist." DSS is also required to develop procedures "in cooperation with state legal authorities for referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced."

In addition to criminal penalties, fraudulent vendors should be subject to suspension from the Medicaid Program following an administrative due process hearing. Other states have found that there are many cases of overcharges, overutilization, and other devious practices which could not be prosecuted in court. In these cases administrative sanctions should be taken by the state. As previously stated, DSS has not taken any action against "aberrant providers," not even collecting the overpayments.

Finally, DSS has not established a mechanism for notifying professional and licensing agencies of any such violations. It appears that DSS does not have a sufficient commitment to the elimination of provider fraud in the Medicaid Program.

Officials at DSS indicated that the absence of an office to investigate fraud was the major reason why there had been no convictions. Officials in the Office of Investigation told us that the lack of state laws which can be used to prosecute abusers of the Medicaid Program was also a major factor.

It was also pointed out by the officials at DSS that a "lack of coordination" exists between Title XVIII (Medicare) and Title XIX (Medicaid). That is, when HEW discovers a case of fraud by a vendor within Title XVIII, they do not notify DSS even though the vendor might be participating in Medicaid also.

Other states who have invested in a Medicaid investigation section have found it to be cost effective. For instance, Maryland and Michigan have found that they recover from $8 to $10 for every $1 spent in investigating fraud and abuse. These states investigate cases of suspected fraud and abuse by program recipients and providers. HEW has recently staffed a new Medicaid Fraud and Abuse Unit. Investigative techniques are being developed and teams of federal investigators are being sent into states with high Medicaid expenditures.

Medicaid investigations are highly specialized in each provider type and require specialized expertise on the part of the investigators. Officials at DSS's Office of Investigation stated that the number of people to be assigned to investigate Medicaid fraud will be based on the office's "workload and demand." DSS has hired a pharmacist that will be working full time in Medicaid reviewing pharmacies. None of the agents, however, will be assigned solely to the Medicaid Program even though this would allow them to devote all of their energies to understanding this complicated program and identifying abuse.

At present, the Department of Health, Education and Welfare estimates that fraud or abuses consume 5% or more of the total Medicaid budget. Applied to South Carolina that 5% would have meant as much as $5,000,000 in FY 76 alone. South Carolina's system for identifying and referring cases of suspected vendor fraud is so weak that reliable estimates of losses cannot even be made. However, if we were to be very conservative and say that fraud and abuse in South Carolina only amounted to 1% of the program, then the state is still losing over $1 million a year.

Medicaid fraud and abuses can take many forms. They include bill padding by doctors, billing for services not provided, double billing on claims already paid, kickbacks by clinical laboratories, prescribing excessive laboratory or x-ray services, and gross overutilization of services.

RECOMMENDATIONS

- THE AUDIT COUNCIL RECOMMENDS THAT THE GENERAL ASSEMBLY BY JOINT RESOLUTION REQUEST THAT THE MEDICAL SERVICE ADMINISTATION OF HEW SEND A FRAUD AND ABUSE INVESTIGATING TEAM TO SOUTH CAROLINA. THESE TEAMS HAVE IDENTIFIED AND INVESTIGATED FRAUD AND ABUSE IN SUCH STATES AS MASSACHUSETTS, TEXAS, LOUISIANA, OHIO, AND NEW YORK. THEY WOULD BRING A MUCH NEEDED EXPERTISE INTO THE STATE WHICH WOULD CONTRIBUTE TO PROGRAM SAVINGS WITHOUT ADDITIONAL STATE EXPENDITURES. ALSO, STATE INVESTIGATORS WOULD BE ABLE TO LEARN, FIRSTHAND, METHODS AND PROCEDURES FOR IDENTIFYING AND INVESTIGATING MEDICAID FRAUD AND ABUSE.
- THE OFFICE OF INVESTIGATION, UPON BECOMING OPERATIONAL SHOULD ASSIGN STAFF TO WORK FULL TIME IN INVESTIGATING FRAUD IN THE MEDICAID PROGRAM. THIS WILL ALLOW INVESTIGATORS TO DEVELOP THE NECESSARY EXPERTISE NEEDED FOR THIS PROGRAM. A MEDICAID FRAUD AND ABUSE UNIT SHOULD BE DEVELOPED TO WORK OUT OF THE OFFICE OF INVESTIGATION. THIS OFFICE SHOULD SEEK CONSULTATION FROM HEW, MICHIGAN, AND MARYLAND IN DEVELOPING AN EFFECTIVE MEDICAID FRAUD AND ABUSE UNIT.

- THE OFFICE OF INVESTIGATION SHOULD UNDERTAKE TO DEVELOP BETTER COORDINATION AND CONTACT WITH THE ADMINISTRATORS OF TITLE XVIII (MEDICARE) IN THEIR INVESTIGATIONS OF FRAUD OR SUSPECTED FRAUD OF PROVIDERS COMMON TO BOTH PROGRAMS.
- THE SOUTH CAROLINA GENERAL ASSEMBLY SHOULD TAKE LEGISLATIVE ACTION TO ESTABLISH A LAW MAKING POSSIBLE THE PROSECUTION OF PROVIDERS (VENDORS) AND RECIPIENTS WHO ABUSE AND FRAUDULENTLY SUBMIT CLAIMS UNDER THE MEDICAID PROGRAM. THIS LEGISLATION SHOULD ALSO INCLUDE PENALTIES FOR STATE OFFICIALS WHO FAIL TO ACT OR KNOWINGLY COVER UP FRAUD. FRAUD STATUTES SHOULD ALSO EMPOWER THE COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES TO SUSPEND A FRAUDULENT VENDOR UNDER THE MEDICAID PROGRAM, AND TO TAKE ANY OTHER ADMINISTRATIVE SANCTIONS AS NEEDED. THE FOLLOWING IS SUGGESTED LEGISLATION:

> Under Title XIX of the Social Security Act, as amended, no vendor of goods or services performed for or sold to any beneficiary shall: (1) Accept payment for goods or services performed, which exceeds the amounts authorized by law for the cost of such goods or services; (2) solicit to perform services for or sell goods to any beneficiary, knowing that such beneficiary is not in need of such goods or services; (3) sell goods to or perform services for any such beneficiary without prior authorization by the welfare department, when prior authorization is required by said department for the buying of such goods or the performance of any services; or (4) accept from any person or source other than the state an additional compensation in excess of the amount authorized by law.
>
> Any vendor found in violation shall be subject to fines of not more than $10,000 or

imprisoned not more than five years, or both. Any such vendor shall be subject to forfeiture or suspension of any franchise or license held by him from the state. Any sums paid in violation of this section may be recovered in an action brought by the state against such person.

Whoever, in any matter within the employment of the State of South Carolina, knowingly or willfully conceals an act of fraud through commission or ommission shall be fined not more than $10,000 or imprisoned not more than five years, or both.

The Department of Social Services shall distribute to all vendors who are providers in the Medical Assistance Program a copy of the rules, regulations, standards and laws governing said program. On or before (date) , the Commissioner of Social Services shall adopt by regulation administrative sanctions against such providers including suspension from said program, for any violations of said rules, regulations, standards or law, said department shall notify the proper professional society and licensing agency of any such violations.

LACK OF PROPER CONTROLS AND SAFEGUARDS IN PROCESSING DRUG CLAIMS

DSS's drug claims processing system is inefficient and does not have the controls and safeguards needed to assure that all claims paid are proper. The result is that frequent overpayments occur which may or may not be caught and the system is vulnerable to paying duplicate and improper claims.

The drug program is one of the fastest growing components of the Medicaid Program in terms of the volume of claims processed. From September 1975 to March 1976 the number of prescriptions processed by DSS rose from 60,000 per month to over 210,000 per month. With this rapid growth, DSS has sacrificed control and accuracy in order to get the claims paid.

Claims come into the processing unit where a clerk counts the lines, or prescriptions, on each claim and batches the claims for data processing. The claims are processed and checks are mailed out to the vendors before they are reconciled back to the claim. With the heavy volume, the clerks may be as much as two months behind on reconciling the payment with the claim. Reconciliation is done by comparing the claim with a copy of the remittance advice that accompanied the check. In reconciling the claim to the payment, the clerks do not compare the quantity dispensed as listed on the claim to what is actually paid. Any error made by data processing in this area will affect what is paid to a vendor and will not be caught by DSS.

In one instance related by a drug clerk, DSS overpaid a pharmacy by $5,000. Data processing through a keypunch error had changed

the number 50 in the quantity dispensed column to 850 for every line on the claim. Since this column is used in computing the drug's costs, the result was the overpayment. The drug clerks do not check this column so the error was not caught. According to the clerk, the only way the overpayment was caught was that the pharmacy notified DSS.

Many of the problems associated with processing the drug claims began when a new machine called a "scanner" was put into the operation. The "scanner" reads or scans a claim form and stores the information on computer magnetic tape. It is at this point of "data entry" that many problems are occurring. The scanner often reads a claim incorrectly transposing provider numbers, changing the quantity of the drug dispensed as well as the drug number itself. Correct claims are often rejected and it is not known how many incorrect claims get through the system.

The major weakness in this system besides the apparent inefficiency is that fraudulent and accidental duplicate claims can be submitted by a vendor and be paid without being detected by DSS. The drug clerk would not catch the duplicate claims since they only compare the payment to a claim form for accuracy. Presently, there is no system to prevent the payment of duplicate claims. Due to the volume of drug claims the control has to be placed in the data processing system.

The computer program does not edit for duplicate claims. If there are duplicate claims in the same processing batch, they will be spotted but duplicates of claims previously paid will not be

identified. Our review found that data processing would process a claim more than once resulting in the vendor being paid twice. The clerks were able to catch these mistakes because there was not a separate claim form for each remittance advice. The vendor then had to be notified to refund the overpayment. We reviewed in June and again in September the outstanding letters requesting refunds. In June, outstanding refund requests amounted to $4,291.59 of which $2,680.16 was because of duplicate payments. In September these amounts were $3,646.10 and $2,145.62, respectively. The totals in September were not composed of the same refund requests that we reviewed in June.

DSS has ten edits, or controls, in its computer processing of drug claims. Two of these edits for which claims will be rejected are "quantity dispensed not payable" and "excessive cost no substantiation." These controls can be suspended by placing an override code on the claim form. An override code keeps the claims that appear to be unreasonable from being rejected by the computer. The override code, however, is placed on the claim form by the pharmacy. This practice nullifies any control that might have been established with the edits. In essence, DSS has established a mechanism to prevent improper claims while at the same time giving the vendors the control over this mechanism. The major effect of all of these weaknesses is that they allow a situation in which abuse can occur and develop into a willful intent to defraud the Medicaid Program.

RECOMMENDATIONS

- DSS SHOULD INITIATE A SPECIAL EFFORT TO GET THE DRUG CLAIMS UNIT CAUGHT UP IN RECONCILING PAYMENTS TO THE CLAIMS.

PROCEDURES SHOULD BE ESTABLISHED AND IMPLEMENTED TO ASSURE THAT PAYMENTS AND CLAIMS ARE RECONCILED BEFORE THE CHECKS ARE MAILED TO THE VENDOR. CLERKS, IN RECONCILING THE CLAIM TO THE PAYMENT, SHOULD BEGIN CHECKING THE COLUMNS CONTAINING THE QUANTITY DISPENSED AS WELL AS THE NUMBER OF LINES PAID.

- OTHER CONTROLS AND EDITS SHOULD BE ADDED TO THE COMPUTER PROGRAMS TO CHECK FOR AND TO DENY DUPLICATE CLAIMS. OVERRIDES OF EDITS SHOULD BE REMOVED FROM THE CONTROL OF VENDORS AND PLACED UNDER THE RESPONSIBILITY OF DSS'S CLAIMS PROCESSING UNIT.
- DSS SHOULD RE-EVALUATE THE EFFECTIVENESS OF ITS DATA ENTRY SYSTEM AND THE USE OF THE SCANNER. PROBLEMS WITH THE SCANNER HAVE TO BE CORRECTED. TO COME UP WITH SOLUTIONS TO THE PROBLEMS DSS SHOULD REVIEW THE SYSTEMS USED BY PRIVATE BUSINESSES WHO PROCESS LARGE NUMBERS OF CLAIMS. ALSO, OTHER STATES SHOULD BE CONTACTED TO REVIEW HOW THEY PROCESS DRUG CLAIMS. SOLUTIONS FOUND SHOULD BE COORDINATED INTO THE DEVELOPMENT OF THE MMIS.

APPENDIX

APPENDIX I

APPROPRIATION INCREASES BY LINE ITEM WHERE WRITTEN JUSTIFICATION WAS NOT PROVIDED IN THE BUDGET REQUEST FY 73 - FY 77

	FY 73	FY 74	FY 75	FY 76	FY 77	TOTAL
ADMINISTRATIVE AND PROGRAM SERVICES						
Personal Service						
(Number of Positions)						
Classified Positions		$ 87,112	$ 810,965	$ 810,965	$ 1,436,623	$ 3,145,665
Unclassified Positions						
Teachers			1,694	1,694		3,388
Other		44,950	45,382	45,382		135,714
Temporary/Part-time Help						
Contractual Services	$ 90,924	412,264	1,001,397	1,537,637	1,967,498	5,009,720
Supplies	5,530	1,755	359,781		580,911	947,977
Equipment		28,612		164,722	105,863	299,197
Fixed Charges and Contributions		31,053	276,276	217,686		525,015
Case Services and Public Assistance Payments	100,000		142,047	83,522	132,565	458,134
Employer Contributions			4,857			4,857
Fees for Services			22,050	2,825		24,875
In-Service Training		2,297	35,363			37,660
Per Diem - Boards and Commissions					806	806
Adult Protective Services					90,000	90,000
ASSISTANCE PAYMENTS						
Aid to Families with Dependent Children	30,124	723,642	723,642	5,193,705	4,378,352	11,049,465
General Assistance				141,880		141,880
Old Age Assistance	167,789					167,789
Aid to Blind	12,468					12,468
Aid to Permanently and Totally Disabled	31,154					31,154
Medical Assistance (Medicaid)	117,378	117,378	3,048,216	3,438,050	10,649,650	17,370,672
Foster Home Care			30,720			30,720
SSI Supplementation			147,294	132,021		279,315
Operation of Day Care Centers			633,471	586,571		1,220,042
TOTAL NOT JUSTIFIED	$555,367	$1,449,063	$7,283,155	$12,356,660	$19,342,268	
CUMULATIVE TOTAL NEVER JUSTIFIED						$40,986,513

APPENDIX II

ALTERNATIVE SERVICES TO NURSING HOMES

Day Care Services for Adults - consist of activities provided in a protective setting for the purpose of personal care and to promote the social health and emotional well-being through opportunities for companionship, self-education, and other satisfying leisure activities.

Meals (congregate and home delivered meals) - this service is designed to ensure the provision of at least one nutritional meal per day to persons who are physically or mentally incapacitated or otherwise unable to care for their nutritional needs.

Chore Services (general household services and minor home repair) - are designed to meet the needs of persons who are unable to perform certain tasks which are associated with independent living in the community. These services include household cleaning; essential shopping; minor household repair; ground maintenance; running errands; meal related duties; aiding persons in maintaining personal hygiene.

Transportation - is a structured multi-purpose system designed to enable persons to travel to and from facilities within the community to receive other services.

Home Health Services - provides health care to individuals as needed in the home. Such services are provided to aged, disabled, or sick or convalescent individuals who do not need institutional

care. Care is provided under the direction of a doctor and includes nursing services; speech, physical and occupational therapy; homemaker services; and social services.

Foster Home Program - is where an elderly person is placed with a family whose home meets certain criteria. This enables the person to be in a family setting. The state pays the family to care for these people.

GLOSSARY

abuse: improper or excessive use of program benefits, resources or services by either providers or consumers.

alternatives to long-term institutional care: the whole range of health, nutritional, housing and social services designed to keep persons, particularly the aged, disabled and retarded, out of institutions like skilled nursing facilities which provide care on a long-term basis. The goal is to provide the range of services necessary to allow the person to continue to function in the home environment. Alternatives to long-term care include day-care centers, foster homes or homemaker services.

carryforward funds: state funds not spent in one fiscal year which may be retained or carried forward to the next fiscal year. The Legislature permits only certain agencies to retain all or part of the state appropriated funds which these agencies have not spent by year end. This permission is granted by means of a special provision in the Appropriation Act known as a "carryforward provision".

categorically needy: persons who are both members of certain categories of groups eligible to receive public assistance, and economically needy. As used in Medicaid, this means a person who is aged, blind, disabled, or a member of a family with children under 18 (or 21, if in

school) where one parent is absent, incapacitated or unemployed and, in addition, meets specified income and resources requirements which vary by state. In general, categorically needy individuals are persons receiving cash assistance under the AFDC or SSI programs. A state must cover all recipients of AFDC payments under Medicaid; however, it is provided with certain options (based, in large measure, on its coverage levels under the old federal/state welfare programs) in determining the extent of coverage for persons receiving federal SSI and/or state supplementary SSI payments. In addition, a state may cover additional specified groups, such as foster children, as categorically needy. A state may restrict its Medicaid coverage to this group or may cover additional persons who meet the categorical requirements as medically needy.

certificate-of-need or necessity: a certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, or offer a new or different health service, which recognizes that such facility or service when available will be needed by those for whom it is intended. Where a certificate is required (for instance for all proposals which will involve more than a minimum capital investment or change in bed capacity), it is a condition of licensure of the facility or service, and is intended to control expansion of facilities and services in the public interest by preventing excessive or duplicative development of facilities and services.

fiscal agent or intermediary: a contractor that processes and pays provider claims on behalf of a State Medicaid agency. Fiscal agents are rarely at risk, but rather serve as an administrative unit for the state, handling the payment of bills. Fiscal agents may be insurance companies, management firms, or other private contractors. Medicaid fiscal agents are sometimes also Medicare carriers or intermediaries.

fraud: intentional misrepresentation by either providers or consumers to obtain services, obtain payment for services, or claim program eligibility. Fraud may include the receipt of services which are obtained through deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received. Fraud is illegal and carries a penalty when proven.

home health care: health services rendered to an individual as needed in the home. Such services are provided to aged, disabled, or sick or convalescent individuals who do not need institutional care.

intermediate care facility (ICF): an institution recognized under the Medicaid Program which is licensed under state law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the

level of room and board) which can be made available to them only through institutional facilities. Public institutions for care of the mentally retarded or people with related conditions are also included.

management information system: a system (frequently automated or computer based) which produces the necessary information in proper form and at appropriate intervals for the management of a program or other activity. The system should measure program progress toward objectives and report costs and problems needing attention. Special efforts have been made in the Medicaid Program to develop information systems for each state program.

nursing homes: generally, a wide range of institutions, other than hospitals, which provide various levels of maintenance and personal or nursing care to people who are unable to care for themselves and who may have health problems which range from minimal to very serious.

profile: a longitudinal or cross-sectional aggregation of medical care data. Patient profiles list all of the services provided to a particular patient during a specified period of time. Physician, hospital, or population profiles are statistical summaries of the pattern of practice of an individual physician, a specific hospital, or the medical experience of a specific population. Diagnostic profiles are a subcategory of physician, hospital, or population profiles with regard to a specific condition or diagnosis.

skilled nursing facility (SNF): an institution (or a distinct part of an institution) which has in effect a transfer agreement with one or more participating hospitals and which is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

utilization review (UR): evaluation of the necessity, appropriateness and efficiency of the use of medical services, procedures and facilities. In a hospital this includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a utilization review committee, PSRO, peer review group, or public agency.

vendor: a provider; an institution, agency, organization or individual practitioner who provides health or medical services. Vendor payments are those payments which go directly to such institutions or providers.